Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 02 **Physician** EDWARX BRNEC 08 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GEN, MARY (AN) BALTIMORE HOSPI TAL BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 M 2 □ F 212-20-6114 Director 22,1925 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County 1 E¥es 2 □ No Funeral Director +i mor e 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21202 Franklyn Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: While þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk UNK unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ UNK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MY 21202 alver Depart of Age Kosondra Luckis n 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1- Burial 2 □ Cremation 3 □ Removal from State OM Z 4 □ Donation 5 □ Other (Specify) arme 18/2008 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility 2829 Skarda Fyrezu Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinednate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) law requires that the death certificate be executed and for use as the burial-trai Due to (or as a consequence of) P.O. Box 68760, attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 12 No certificate Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 3 ☐ D**O**A 1 Tyes Impatient 2 ER/Outpatient Medical Certification: To After this 27. Mann Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Matural 5 Pending Injury hours after death.
uneral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b. 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contine

Registrar

31. Date filed (Month, Day, Year)

9

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m.D.

32 Registrar's Signature

08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. C. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 2000 **Physician** 5:00 AM Robert feb /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bank was Berria Bankuille Baihmond. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) July 4 1935 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 XX 2 □ F Yrs. 72 Moncoal, W Va. 213 30 2499 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 ☐ No Director Baltimore Baltimore County Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 USA 6707 Beech Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Roofer Roofer's Union 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Q Daniel Velma Lynvale ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21206 6707 Beech Avenue Beverly A Daniel 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc February 16 2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lassahn Funeral Home Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory a rest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Vementon 42243 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the and be detached for 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NIDDM 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No CAF 24a. Was an autopsy performed 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA £ After thi funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Registrar

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

& Kless

Kluesz

DHMH 17 Rev 1/2001

State

29c. License number

Sute

3/295

4262

29d. Date signed (Month, Day, Year)

21204

2/15/08

and manner stated.

6701 N Charles St

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY **Physician** Bernice Daniels /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Towson Saint Joseph Medical If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5 Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months 1 M 2 F Director 212-12-6652 Usual Residence of Decedent Aug 25, 1925 10a. State 10b. County 10c. City, Town or Location Directo **Baltimore** N/A Marvland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21230 1003 Leadenhall Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 212 No Specify. <u>م</u> 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phoebe Graves ပ George Graves 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1928 North Payson Street Baltimore, Maryland 21217 Frances Dixon Daughter 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 02/26/08 Crownsville Veterans Cemetery 22. Name and Address of Facility 21. Signature of uneral Service Licens Estep Brothers Funeral Service, P. A. Do not enter the m 1300 Futaw Place Baltimore, Md 21217 23at 1. Enter the J sease, or complications that cause the shock, or heart f liure. List only one cause on each line. the de V Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): **Examiner** ASPIRATION PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy

23d. Date of delivery in the past 12 months? 1 Yes 2 No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à DIABETES MELLITUS TYPE II 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an HYPERTENSION autopsy performed? Yes 2 No DEMENTIA 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∏X No မှ 1X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 08 D 37254

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2008

Baltimore

U.S.A.

Own Home

Crownsville, Md.

Approximate Interval Between Onset and Death

14. Race - American Indian

Black, White, etc.

Specify.

1:30A

Birthplace (State or Foreign Country)

Maryland

Black

10d. Inside City Limits 1 Nes 2 No

DHMH 17 Rev 1/2001

State Registrar

signed by t

page 2 should

After this

within 24 hours after death To the Funeral Director:

filled in by

To the Hospital or Attending Physician:

ORIGINAL

OSLER DRIVE. TOWSON, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

IM.

7601

32. Registrar's Signature

31. Date filed (Month, Day, Year)

08-01381

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Physician/ 1. Decedent's Name (First, Middle, Last) | Certificate of | Dodin | | | Reg. No. 💪 🐛 | | | | | |
|--|--|--|------------------|---------------------------|-------------------------------------|--|--|--|--|--|
| 10 - 1 | F | DAVYDOV | | | 2. Date of Death 3. Time of | | | | | |
| edical Examiner N15UN 4a. Facility Name (if not institution, give street and number) | | DAVIDUV | Location of De | | / 17, 2008 | 0959 hrs | | | | |
| 6962 Milbrook Park Drive | | Pikesville | 2004.1011 01 201 | u., | Baltimore | • | | | | |
| Talleral | rs. last birthday) | If Under 1 Year Months Days | | | Birth(MM/DD/YYYY) 9 | oreign | | | | |
| Director 050-84-5364 1X M 2 F | 58 Yrs. | | Hours | 12/2 | 26/1949 | Country) RUSSIA | | | | |
| Usual Residence of Decedent 10a. State 10b. County 10c. C | City, Town or Locati | on | | | | 10d. Inside City Limits | | | | |
| T P E E B MD BALTIMORE B | ALTIMORE | | | | | 1 Yes 2 X No | | | | |
| The Street and Number 6962 MILBROOK PARK DRIVE, A | DT TO | 10f. Zip Code | 1015 | | 10g. Citizen of What | Country? RUSSIA | | | | |
| 6962 MILBROOK PARK DRIVE, A | | s Decedent of His | 1215 | Specify Yes or I | | American Indian, Black, | | | | |
| 11. Marital Status 1 Never Married 2 X Married 1 Yes 2 X N | If Y | es, specify Cuban | | | White, e | etc. | | | | |
| 3 Widowed 4 Divorced If Yes, Give Year or Dates: | 1 | Yes 2 X No | | | Specify: | WHITE | | | | |
| 15. Decedent's Education (Specify only highest grade completed by Elementary/Secondary (0-12) College (1-4 or 5+) | | t's Usual Occupati ost of working life. | | | 16b. Kind of Busin | LOTHING | | | | |
| 15. Decedent's Education (Specify only highest grade completed on the complete compl | | OWNER | R | | MANU | JFACTURER | | | | |
| ₹ ≒ ≒ ∃ ₽ □ DAVID | DAVYDOV | | | me (First, Middle EZDA | e, Maiden Surname) A | SHUROVA | | | | |
| C 20 10 10 10 10 10 10 10 10 10 10 10 10 10 | | | | | lumber, City or Town, | | | | | |
| LARISA DAVYDOVA / WIFE | 6716 Ob. Place of Dispos | | | Date Date | IMORE, MD | 21209 ity or Town, State | | | | |
| 1 X Burial 2 Cremation 3 Removal from State | crematory or oth HAR S | her place) | - | /19/2008 | | MILLS, MD | | | | |
| 20a. Method of Disposition 1 X Bunal 2 Cremation 3 Removal from State 2 Donation 5 Other Specify; 21. Suparture of Fundamental Service Licenses | | | | | NSON & BRO | - 1 | | | | |
| m & a & E E William Museu | 890 | OO REISTE | ERSTOWN | ROAD - | PIKESVILL | E, MD 21208 | | | | |
| Physician 23a. Part I. Enter the disease, or complications that caused the defailure. List only one cause on each line | | | | ac or respiratory | arrest, shock, or heart | Approximate Interval Between Onset and Death | | | | |
| Immediate Cause (Final disease or condition resulting in death) a. Ethanol and ox Due to (or as a consequence) | - | toxication | | | | | | | | |
| Sequentially list conditions, b | ce of): | · | | | | | | | | |
| cause. Enter Underlying Cause (Disease or injury that initiated | | | | | | | | | | |
| events resulting in death) Last Due to (or as a consequence of the con | ce or): | | | | | | | | | |
| d. Amended | perME.g87 | 7, 3/3/08 | IT | | | | | | | |
| TF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of past 12 months? | pregnancy | etal death 3 | Ectopic pre | egnancy | 23d. Date of de Month | elivery Day Year | | | | |
| Spanning to the part of the past 12 months? O A C Spanning to the past 12 months? O B C C C C C C C C C C C C C C C C C C | of death | her (Specify) | | | | | | | | |
| Yes 2 No 9 Unknown 9 Unknown A Pregnant at time of 9 Unknown | not resulting in the | underlying cause g | given in Part I. | 23e. Di | d tobacco use contribu | ute to the cause of death? | | | | |
| O d hat the significant conditions contributing to death but r | | | | 1 🔲 | Yes 2 No 3 | Probably 4 Unknown | | | | |
| Records, The law require freate has been signated a spage 2 should be Completed | | | | | topsy pri- | ere autopsy findings available or to completion of cause of | | | | |
| Recorded has been a second has | | | | | rformed? de s 2 ✓ No 1 | ath? Yes 2 No | | | | |
| 25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 | | | Other Nu | eck only one) | Residence 6 | Othor: Score | | | | |
| examiner? A continue Continu | 2 ER/Outpatient 28b. Time of I | | ry at Work? | | be how injury occurred | | | | | |
| 1 Natural 5 Pending Investigation Find 2/17/200 | 08 Fnd 9:50 | o am | Yes 2 X No | unk | | | | | | |
| Size 2 2 2 3 3 Suicide 6 X Could not be 28e. Place of Injury | At home, farm, stre | | ouilding, etc. | 28f. Locatio | n (Street and Number | or Rural Route Number, City Dr. Pikesville, MD | | | | |
| 29a Certifier | nd a thome | rred at the time, da | ate and place | | | | | | | |
| 29a. Certifier 1 Certifying Physician: To the best of my know one) 2 Medical Examiner: On the basis of examinating and manner stated. 29b. Signature and title of certifier | The second secon | | | | | | | | | |
| 29b. Signature and title of certifier | | 29c. Licens | | | 29d. Date signed (Month, Day, Year) | | | | | |
| toulu- foller | 10 | O.C. | M.E. | | February 18 | , 2008 | | | | |
| 30. Name and address of person who completed cause of death (Patricia Ardnica-Pollak MD. Assistant Medic | | 111 Penn St | treet, Baltin | nore, MD 21 | 201 | | | | | |
| State 31. Date filed (Month, Day, Year) 32, Registrar's Sig | | WE . | | | | | | | | |

DHMH 17 Rev 1/2001 OCME 2006

DOME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month NICKSON 05:30AM **Physician** UCIUS MCNAIRY FER 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWAR. COLUMBIA HOWARD COUNTY GEN HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1**∑**M 2□F July 19,1929 Mississippi 577-34-5261 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at 1 ☐ Yes 2 ☐ No Directo Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 U.S.A. 10717 Atutmn Splendor Drive Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∏Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify. White 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) American Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Commerical Lending Officier Security Bank 12 should be filed w h and Mental Hygien 7 is marked other th permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LaDelle Ingram Lucius McNairy Dickson, Sr. ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10717 Autumn Splendor Drive Columbia, MD 21044 Joanne Dickson-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Lakeside Cemetery 2-17-2008 Dover, Delaware 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Witzke Funeral Homes, Inc.
5555 Twin Knolls Road Columbia, MD 21045 21. Signature of Funeral Service Licensee M01050 Hadema 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** PTIC /Medical Due to (or as a consequence of): **Examiner** 11ROSEPSIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner PROSTATE CANCER as the burial-transit ME THSTATIC Due to (or as a consequence of): physician pe (Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No. 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ UNRES PUNSIVENESS 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 ∐ Yes 2 No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier

To the within

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

or Vital Records.

Division

State 31. Date file

TKE CHUK WU
31. Date filed (Month, Day, Year)

14155m C

n, Day, Year) 32. Rustrar's Signature
FFB 2 0 2008

MBONU:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5755

CEDAR LANE

COLUMBIA MO 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Year Charlene 13. pM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 1405 whireit Ralter Courity p. 101 Conter 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** 1□M 2□F Months Days 304-46-5363 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Me I cal Examiner must be notified at Pikesville 1 ☐ Yes 2 No Director 10g. Citizen of What Country? tree L Be Completed by Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 3 Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Ö 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil ment of Health and Mental H tant: If item 27 Is marked otl Drou ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health at Important; If Item 27 Is any Injury or other trau once, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimure, 4 ☐ Donation 5 ☐ Other (Specify) Voughn C. Green e June 8 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ibaty Rd . Randallston, MDZ1133 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** Jeps is days /Medical Due to (or as a consequence of): Examiner Ena stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Years Due to (or as a conseque ce of): Examiner The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day 4□Pregnant at time of death ed by the a 9☐Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Wound injections 24a. Was an has autopsy perform this certificate Im 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1. Impatient 2 ER/Outpatient 3□ DOA 28b. Time of after death. 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral [29a, Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) DU056632 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Lee- Gardie 31. Date filed (Month, Day,

5411 old lan 32. Registrar's Signature KD.

Randalshun mo Jus

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U U 8 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 6:39 PM "Physician 17 annie FEB 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ST. AGNES HEALTH CARE BALTIMORG 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** MD. 1□M 2**D**F 218-46-8973 60 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ith and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD 1√Yes 2 No Baltimore Funeral Director 10g. Citizen of What Country? 10f, Zip Code 10e, Street and Number Lauretta Avenue 21223 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life._DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Verizon IPPOY T 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19shack Elilah <0sa ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pear NJ 20525 20b. Place of Disposition (Name of cemetery, crepatory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore 2-23-08 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility recent Funeral Services Vaughn Estimore, Maryland 21229 21. Signature of Funeral Service Licensee reene 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CANCER METASTATIC BREAST 2YAGOI disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Cinknown Hypertension Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 【YNo autopsy performed' Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1'Minpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA မ 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number P 19923 Suvaechala TEB, 17, 2008 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KOMPELLA 900 S-CATON AUE, BALTIMORE, 21229 SUUARCHALA 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Sterling Francis Flohr February 15, 2008 11:00 p^M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examine Dove House Westminster Carrol1 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Country) | Jan. 20, 1925 | Maryland Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, Sex XXM 2□F **Funeral** 83 219-18-9076 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a, State 1 □Yes XXNo Director MD Carrol1 Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or 505 High Acre Drive Apt. 201 21157 U.S.A. ms 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, d other than "natural", or Items event, the Medical Examiner mu 11. Marital Status Black, White, etc. 1 ☐ Never Married XX Married Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) C&P Telephone Engineering Assistant 7 is marked other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fi and Mental ► Be Sterling Israel Flohr Margie Rebecca Grimes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 : Health a permit. Pages 1 an
Department of Healt
Important: If item 27
any Injury or other tr. Miranda Elizabeth Flohr / 505 High Acre Drive Apt. 201 Westminster, MD Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) Lake View Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 5 Other (Specify) 2/20/08 4 □ Donation Sykesville, MD 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. un / Servi Licensee 21. Signature 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner no Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Examine requires that the death certificate be executed physician and s the bunal-tran Due to (or as a consequence of): Box 68760 Physician/Medical ass attending p IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð 1 Tyes 3 ☐ Probably 4 ☐ Unknown Completed peen Mere autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 2 □ No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 6 E ther (Specify) Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how intery occurred 28c. Injury at Work? After t To the Hospital or Attending 1 ■ Natural 2 ■ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed or Street 1 NOSTHIUST State 20 FEB Registrar

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 12:06 AM pruay 2008 acility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Balhmore N/A If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 M 2 F 218-28-3040 Jun 20, 1930 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Linthicum Heights Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6530 Harrison Avenue 21090 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Red Roof Inn Cook 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary E. Dailey Thomas Simms 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6530 Harrison Avenue Linthicum Heights, Maryland 21090

Date

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show eny Injury or other traumatic event, the Medikal Exeminer must be notified at Baltimore, Maryland 21215-0036 **Physician**

Physician

/Medical

Examiner

Directo

Funeral

by

Completed

Be

Nathaniel Gales Husband

20a. Method of Disposition

10a. State

Funeral

Director

within 72 hours after death with the Maryland

/Medical Examiner

physician end To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician enforced by the attending physician enforced completely filled in by the funeral director, page 2 should be detached for use as the burnari-transit

Division or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)

| | 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Rem | | Place of Disposition (A cemetery, crematory of | lame of rother place) | Date 2 | Oc. Location - City | or Town, State | | | | | |
|---|---|---|--|--|---|---------------------------------------|---|--|--|--|--|--|
| | 4 Donation 5 Other (Specify) | loval from State | Crownsville Ve | eterans Cemetery | 02/21/08 | Crow | vnsville, Md. | | | | | |
| | 21. Sign Vir of Funeral Service Licensee | P) | 22. Name | and Address of Facility | | | | | | | | |
| | Coll Co | 25/0/A. | PA- | Estep Brothers Fu 1300 Eutaw Place | ineral Service, Baltimore Mo | P. A. 121217 | | | | | | |
| | 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | |
| | Immediate Cause (Final disease or condition resulting in death) | Brainsle | Onset and Death | | | | | | | | | |
| | | Due to (or as a consequence of): | | | | | | | | | | |
| miner | Sequentially list conditions, b. | Due or as a consec | person consequence of: | | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. | ENISTAR | 10 days | | | | | | | | | |
| Exa | resulting in death) Last | Due to (or as a correct | queпсе of): | 7 | | | - 0~ | | | | | |
| Completed by Physician/Medical Examiner | d. | | | | | | | | | | | |
| | | | | | | | | | | | | |
| | IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 | | | | | | | | | | | |
| ed by Ph | Part II. Other significant conditions contrib | buting to death but not res | sulting in the underlying | cause given in Part I. | 23e. Did tob | | e to the cause of death? Probably 4 Unknown | | | | | |
| plet | | , | , | | 24a. Was an | | e autopsy findings available to completion of cause of | | | | | |
| E O | autopsy priori performed | | | | | | | | | | | |
| | 25. Was case referred to medical examiner? | - | | | eath Check only one | | Yes 2. No | | | | | |
| ٥ | 1 Yes 2 No Hos | | ER/Outpatient 3 | | Home 5 Resider | nce 6 Other (5 | Specify) | | | | | |
| ation: | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how | v injury occurred | | | | | | |
| Certific | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | eet and Number of State) | er or Rural Route Number, | | | | | | | | | |
| Medical Certification: To Be | 29a. Certifier 1 CertifyIng Physici (Check only one) 2 Medical Examiner | ian: To the best of my known: On the basis of examinations and manner stated. | owledge, death occurre ation and/or investigati | ed at the time, date and place on, in my opinion, death occ | ce, and due to the ca curred at the time, da | use(s) and manne te and place, and | r as stated. due to the cause(s) | | | | | |
| Š | 29b. Signature end title of certifier | .1.0 | 2 | 9c. License number | | d. Date signed (M | | | | | | |
| | NA hard by | VIAC | | V Y (/)/// | 172 | 010/11/11/10 | 12.2000 | | | | | |

20b. Place of Disposition (Name of

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sahur Kohamim, MD Hayby Hos Pilal 3001 S. Hawver St, Bulhmore MD 2122

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Month terrury INIFRED /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death Examiner BALTIMOREWASHINGTON NEDICAL ENTER BURNIE ANNE GLEN If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Feb 7, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2**X** F 214 38 3158 Massachusetts Director 1920 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show ed other than "natural, or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2XINo Director MD Anne Arundel Linthicum Heights 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21090 820 Main Avenue United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married しては十つ。 Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No þ Specify. 3√2 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi and Mental E Be Leslie George Bennett Annie Atkins ပ injury or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m Catherine B. Gerstbrich/Daughter 820 Main Avenue Linthicum Heights, MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Columbia Memorial Pk. 2-23-2008 Clarksville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee n Collis MO1044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death shock, or heart fallure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner the attending physician and hed for use as the burial-transit certificate be exec Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as 1 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav 5 ☐ Other (specify) signed by the a 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an cate has page 2 s autopsy performe certificate the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after deau.

To the Funeral Director: After this committeely filled in by the funeral dir 2 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2008

State Registrar

31. Date filed (Month, Day, Year)

FEB 2 0 2008

30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print)

MD

32 Registrar's Signature

30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician 8:30 A M Louis Grunke February 18, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cherry Lane Nursing Home Laurel Prince George 8. Date of Birth (Month, Day, Ye Jan. 12, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York **Funeral** Days Hours Year) 1₩ 2□ F 129-12-2662 88 1920 Director Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1∏Yes 2∏No Director MD Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iral", or Items 23a or Examiner must be r 7413 Berryleaf Drive 20707 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 KMes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXIVo Specify Specify: Completed by 3 X Widowed 4 Divorced WWIT White 'natural" the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Tool & Dye Mental Hygiene. arked other than Elementary/Secondary (0-12) College (1-4or 5+) Casting Company Grade 12 Owner/Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked o Charles Grunke ALexandra Feeiberg 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a 14 Laurel Hill Road, Unit Z-1 Greenbelt, MD 20770 Mary Anne Patricia Cullinan 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 20c. Location - City or Town, State Department of Important: If Its any Injury or o once. 1XXBurial 2 ☐Cremation 3 ☐Removal from State Union Cemetery 4 □ Donation 5 □ Other (Specify) 2/22/2008 Burtonsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. /M00770 313 Talbott Avenue Laurel, Maryland 20707 complications that caused the death. Do not enter the mo to f dying, such as cardiac or respiratory arrest, anly one cause on each line. 23a. Part1. Enter the disease, of shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or a a consequence of): **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy or in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a 9 Unknown s been signed by the should be detach. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Were autopsy findings available prior to completion of cause of page 2 s autopsy performe this certificate or Attending Physician; director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Yes 2 | No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To uneral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred (Month, Day Year 1 Natural 5 Pending investigation 1 🗌 Yes 2 ☐ Accident the Funeral Director: npletely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

Darryl

13635 Baltimore Avenue

29c. License number

0053235

Laurel,

MD

29d. Date signed (Month, Day, Year)

20707

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anthony Hill,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 0.501Certificate of Death Reg. No.--1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Barbara рм 02/14/2008 6:38 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9221 Dunloggin Road Ellicott City Howard 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 3/21/1942 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 ☐ X 218-36-7501 65 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at MD Howard Ellicott City 1 ☐ Yes 2 ☐ No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 9221 Dunloggin Road 21042 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Ite 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 XNo 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No White Specify: þ Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Senior Customer Service Rep Baltimore Gas & Electric 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marcus Michael Kelly Ruth Stamm 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other tra once. 9221 Dunloggin Road, Ellicott City, MD 21042 Colleen Lewis / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State Meadowridge Memorial Park 02/19/2008 4 ☐ Donation 5 ☐ Other (Specify) Elkridge, MD 21. Sign wre of F 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, 7250 Washington Blvd., Elkridge, MD neral Service Licer M01378 23'. Part1_Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. xx, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immeriate Cause (Final sease or condition resulting in death) Metastatic Colon Cancer **Physician** years /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter the deflying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and Due to (or as a consequence of) burialphysician Physician/Medical the ass IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 🗷 No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ TNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 1∐ Yes 2**X** No director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2X No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760, P.O. Division or Vital Records,

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed The Hospital or Attending Physician: in 24 hours after upon. The Funeral Director: Aft

To the To the

State

Registrar

Medical

4 ☐ Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

02/15/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Cheryl D. Leonardi, MD - 4801 Dorsey Hall Drive, Ellicott City, MD 21042

31. Date filed (Month, Day, Year) FEB 2 0

29b. Signature and title of certifier

29a. Certifier

State Registrar

LEONARD RICHARDSON 31. Date filed (Month, Day, Year)

M.D. 1838 GREENE 32. Registrar's Signature

FEB 2 0 2008 ORIGINAL



TREE RUAD #300

PILLESVILLE

State of Maryland / Department of Health and Mental Hygiene Amend Item 26 per verb., g876,02/29/08/hbeath 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 11:00 PM Hermann Leon Hegner 2008 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Jan 21, 19 9. Birthplace (State or Foreign Country) WestVirginia 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral 1**X** M 2□ F Months 236-64-1097 68 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturai", or items 23a or 28a-f show 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at Maryland Frederick Frederick 1X Yes 2 □ No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 819 North market Street, # 1 21701 U.S.A. Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Vietnam Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Associate Retail Stores 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be marked Hermann Hegner Angela Emig 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Barbara C. Hegner, Wife P.O. Box 3783, Frederick, Maryland 21705-3783 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: if it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory Feb 13, 2008 Smithsburg, Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Keeney & Basford P.A. Funeral Home
M00706 106 East Church St, Frederick, Maryland 21701 21. Signature of 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Assytole disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Hypercap nia
Due to (or as a consequence of): HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Huidemic HOURS attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, use as t IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccouse contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate Hospital or Attending Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 7 No Certification: To 1 🔀 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) Cercen MD 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mospitel, Frederick, MD 21701 Muduson Fredmile Menoril 31. Date filed (Month, Day, Year) FEB 2 0 2008 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

08-00587 Charles Hudson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| harles Hudson | State of Maryland / Department of Health and Mental Hygiene 1-For State Registrer Certificate of Death Reg. No. 2008 0501 |
|--|--|
| Physician/ Medical Examine | Month Day real 1052 hrs |
| * | Charles Hudson 4a. Facility Name (if not institution, give street and number) 106 Webb Court January 21, 2008 4c. County of Death Baltimore |
| Funeral Director | 5. Social Security Number and 6. Sex 1. Age (In yrs. last birthday) 1. Months Days Hours Min. Dec 30, 1955 Foreign Country) |
| v any | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits |
| Maryland 28a-f show any d at once. rector | MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? |
| with the Maryland ms 23a or 28a-f sho be notified at once erral Director | |
| or death | 11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1 Yes 2 X No specify: 1 Yes 2 X No specify: 1 Yes 2 Dack 1 Yes 2 Dack 1 Yes 2 X No specify: 1 Yes 2 X No specify: |
| hours afte 'natural'' Examine | 15 Decedants Education (Constitution (Constitution and a completed) 15 Consequently Liquid Constitution (Clark Kind of Business/Jodustry 110) K |
| 5-0036 ed within 72 hour lygiene. other than "natt he Medical Exat | Elementary/Secondary (0-12) College (1-4 or 5+) unk unk |
| 7 2 2 2 4 Q | |
| MD 2121(dd 2 should be fill alth and Mental F m 27 is marked aumatic event, 1 | |
| 0 8 5 5 E | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) |
| Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr | 21. Sign the of Fun-ral Service Licensee Director 22. Name and Address of Facility Board 655 W. Baltimore Street |
| Physician /Medical | Baltimore, MD 21201 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and |
| caminer | Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): |
| j | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): |
| nted d ansit Examiner | c. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): |
| 50, te be executed ysician and burial - transit | UNPENDED AMENDED |
| Ox 6876 ath certifica attending ph or use as the | |
| P.O. Besthat the degree by the defacted for the degree by the best of the both by the both | |
| Division of Vital Records, P.C tal or Attending Physician: The law requires that its after death. al Director: After this certificate has been signed led in by the funeral director, page 2 should be death artification: To Be Completed by | 24a. Was an autopsy prior to completion of cause of death? 1 V Yes 2 No 1 V Yes 2 No |
| ital Recition: The lician: The lician: The licians is certificate licector, page | 25. Was case referred to medical 26. Place of Death (Check only one) |
| of Vit | 1 Ves 2 No Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Vother: Scene |
| ion of Iteuding Pheleath. tor: After to the funeral | 1 V Natural 5 Pending 2 Accident Investigation (Month, Day, Year) 1 Yes 2 No |
| Division o Hospital or Attending 24 hours after death Funeral Director: After | 3 Suicide 6 Could not be 4 Homicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) |
| To the Hospital within 24 hours. To the Funeral completely filled | |
| F 3 F 3 B | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 22, 2008 |
| | 30. Name and address of person who completed cause of death (Item 23a) |
| | Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 |
| State Registra | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** William Derek 5 2008 eb /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Months 1 XM 2 ☐ F Yrs. 70 Dec. 7, 579-72-5132 1937 Director England Usual Residence of Decedent 10d. inside City Limits 10c. City. Town or Location 10a. State "natural", or Items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2X No Director Anne Arundel Laurel 10e. Street and Number

8243
4245 Lyndhurst Street 10f. Zip Code 10g. Citizen of What Country? United Kingdom 20724 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify: White 3 ☐ Widowed 4 💆 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Guard 10th British Embassy permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important; If Item 27 is marked other any Injury or other traumatic event, It 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emily Pedley Charles Hexley ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Moss Drive Sutton Cold Field, England B7
position (Name of Date 20c. Location City or Town, State Derek Hexley/ Son B721J0 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/19/2008 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** Dheumoni days /Medical Due to (or as a consequence of) Examiner mouth: e tastasic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed attending physician and I for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) isigned by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | Probably 4 | Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? perform certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? To the Hospital or Attending within 24 hours after death. To the Funeral Director: After Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide printing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0062545 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

12

State Registrar Date filed (Month BB 270 2008

5755



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State amend #25&27 Per FH G876 2/26/16/90 aff of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** SCI DOUYAM 2001 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Med e. N Oil cee If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthdav) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ☐ M 2 🛣 F Yrs Director 213 32 6812 72 1935 Nov 6, Marvland Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2X No Director Howard MD Ellicott City 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3822 Spring Meadow Drive 21042 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify. 3 ☐ Widowed 4 ☐ Divorced White th and Mental Hygiene.
77 is marked other than "natur traumatic event, the Medical is Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director of Nursing Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank West Elsie Webb 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any injury or other trainonce. Louis F. Huber/Husband 3822 Spring Meadow Drive Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 2-21-2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset/and Death Immediate Cause (Final **Physician** Tracture R4 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy been signed by the atte should be detached for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 🗹 No 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed MO. 6 0 CaranomA Ne 1□ Yes 2 No 25. Was case referred to medical examiner? **Director:** After this certific In by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) XXYes 27No 1 Inpatient P 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Accident 5 Pending investigation 281. Location (Street and Number or Rural Route Number, City or Town, State) 3822 Spring Weldow D. Elizott City 1 ☐ Yes 2 00 -12-08 Munom 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completely filled home within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Dav. Year) and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32 Registrar's Signature Year, State FEB 2 0 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HAWES Month Vear 3:35 PM **Physician** FEBRUARY 16 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RALTIMORE HOSPI N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ▼ M 2 □ F 217 07 8601 88 11/04/1919 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
nt: If them 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10h. County 1 ☐ Yes 2 📉 No Baltimore Baltimore Director Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 3 2711 Yarnall Road U.S.A. 21227 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WW II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Cab Driver Cab Company 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John F. Hawes (Not available) Antonia ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Hawes / wife 2711 Yarnall Road Baltimore, Maryland 21227 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 02/19/2008 Baltimore, Maryland 4 Donation 5 Other (Specify) 22 Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 21. Signature of Funeral Service Licensee 23a. Part I. Erlier the "iseas", or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PHLURE **Physician** CONGES /Medical DARY TO ISCHEMIC CARMOMOPATHY Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician a for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier PHYYCIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BEBU WITH HANCVER 3001

Registrar

Registrar's Sig

0°2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 0502 State of Maryland / Department of Health and Mental Hygiene Cornelius Johnson, Jr. Certificate of Death 1- For State Req. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 11, 2008 1942 hrs ◄ Examiner Johnson, Cornelius 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Randallstown Liberty Road and Schnaper Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. Country) /25/1953 Md. Director 1 🔀 M 54 218-60-2790 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 1 X Yes 2 No items 23a or 28a-f show ust be notified at once. Baltimore Randallstown permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatie event, the Medical Examiner must be notified at once. rector 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21133 ä 3715 Live Oak Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or Noera 12. Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Fun 2 X No Yes Specify:Black Yes 2 X No specify: Divorced If Yes, Give Yaar à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) fed College (1-4 or 5+) Elementary/Secondary (0-12) Comple 21215-0036 Mirage Hall Custodian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shirley D. Gordon Be Cornelius Johnson, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 3715 Live Oak Rd., Randallstown, Md. 21133 Baltimore, MD Shirley Gordon 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State 2/18/2008 Baltimore. rbutus Cemetery Donation 5 Other 22 Name and Address of Facility
ESTEP Brothers Funeral Service nature of Funeral S 21217 1300 Eutaw Place., Baltimore, Approximate Interval complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ohysician Part I. Enter veen Onset and failure. List only one cause on each line Death Medical a. Multiple Injuries Immediate Cause (Final disease .xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical signed by the attending physician and be detached for use as the burial -UNPENDED AMENDED To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö Yes 2 ✓ No 3 Probably 4 Unknown ş σ, Completed 24b. Were autopsy findings available ficate has been si page 2 should b 24a. Was an of Vital Records, autopsy prior to completion of cause of death? performed? No 1 🗸 ✓ Yes 2 certificate 26.Place of Death (Check only one) 25. Was case referred to medical director, Be Other 4 Residence 6 Other: Scene examiner? Hospital: 1 Nursing Home 5 Inpatient 2 ER/Outpatient 3 this 1 V Yes No ۵ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Pedestrian struck by auto Certification **FOUND** Yes 2 V No 1 Natural Division 5 Pending within 24 hours after death To the Funeral Director: Feb 11, 2008 1940 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by or Town, State) Liberty Rd at Schnaper Dr, Randallstown, Md 3 Could not be Suicide determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

Ana Rubio MD. 31. Date filed (Month, Day, Year) FEB 2 0

32. Registrar's Signature Compression of the second

30. Name and address of person who completed cause of death (Item 23a)

2008

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

February 12, 2008

08-01244 Benjamin Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 05022

| senjar | min Jones | 1- | For State | state of ivi | arylaria / Do | Certifi | icate of | Death | | | Re | eg. No. | | | | |
|--------|---|----------------|---|----------------------------|---|-------------|-----------------|--|----------------------|-------------|---------------------------------|---------------------|------------------------|-------------------------------------|---------------------------|-------------|
| | Physicia | | gistrar Decedent's Name (First, Mi | ddle,Last) | | | | | | | ate of Dear Ionth ebruary | | Year | | Time of Death 1840 hrs | ` |
| Med: | ' Examir | er. | BENJAMIN LINV | IARD JON | IES | | | o. City, Town, or L | ocation of I | | ebruary | | County of | | | |
| | | 4 | a. Facility Name (if not institu | | t and number) | | 140 | Baltimore | .ocallon or i | Death | | | | | | |
| | | | Maryland General H | 6. Sex | 7. Age (In | vrs. last i | birthday) | If Under 1 Year | If Under | 24Hrs. 8. | Date of Bi | rth(MM/E | OD/YYYY) | g. Birthpl | lace (State or | |
| | Funeral Director | 5 | . Social Security Number | | _ | | Yrs. | Months Days | Hours | Min. | APR. 2 | 28. | 1943 | Foreign Count | ry) MD | |
| | Director | - | 217-40-7086 Sual Residence of Deceden | 1 X M 2 | ZF | 64 | | | | | 11.10 | | | | o t to de Cho | Limite |
| | any | | 0a. State 10b. Cour | | 10c | . City, To | wn or Location | on | | | | | | | 0d. Inside City | |
| | * | _ | MD | | | BAL | TIMORE | | | | | 10 0''' | zen of Wh | | | |
| | arylar 8a-f s | Director | 0e. Street and Number | | | | | 10f. Zip Code | | | | _ | | at Country | y: | |
| | vith the Maryland s 23a or 28a-f show a e notified at once. | ᡖ | 901 DRUID HI | LL AVE. | | | | 21201 s Decedent of His | io Origi | n2 / Specif | fy Ves or N | | JSA 14. Race | - America | n Indian, Blac | k, |
| | h with | Funeral | 1. Marital Status 1 X Never Married 2 | Married 12. | Was Decedent Eve Armed Forces? | | 13. Was | s Decedent of His es, specify Cuban | , Mexican, | Puerto Ric | an, etc.) | | White | | | |
| | or ite | 튒 | | Divorced If Yes | Yes 2 X | No | 1 | Yes 2 X No | specify: | | | | Specify: | BLAC | CK | |
| | rs afte ural", miner | à- | Widowed 4 | | | ted) 1 | So Docoden | t's Usual Occupat ost of working life | ion (Give k | ind of work | k done | 16b. l | Kind of Bu | siness/Ind | dustry | |
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| • | 5-0036 Iled within 7 Hygiene. I other than | Ŝ | 17. Father's Name (First, Mi | | | | | | | | CLAIB | | | , | | |
| | 121 d be fi lental arked | o Be | JAMES A. JON 19a. Informant's Name/Rela | ES | Print) | | 19b. Mailin | g Address (Stree | et and Num | ber or Rur | al Route N | umber, C | City or Tow | n, State, | Zip Code) | |
| | MD 21 d 2 should lth and Mer n 27 is man | F | PATRICIA JON | | | | 1720 | E. 25TH | ST. | | rimor | E, M | D 21 | 213 | Ctata | |
| | e & - | | 20a Method of Disposition | | | | ace of Dispor | sition (Name of ce | emetery, | | Date | 19 | 03 H | DLLIN | rown, State IS FERR | |
| | ages lant of H | | 1 X Burial 2 Crem 4 Donation 5 Oth | | Removal from State | | MT. | ZION | | 02/1 | 9/200 | 8 BA | LTIM | ORE, | | 227 |
| | Baltimore, permit. Pages I at Department of He Important: If ite | | 21. Signature of Funeral Se | rvice License | 1 | | 22. | Name and Address | | WES: | LEY C | HAVI | S, J | R. FN | JRL. HM | l. |
| | Dep Dep | | Wesley | Cha | witi | | | 2007-09 | EAST | ERN A | VE., | BAL/I arrest, st | TMOR | E, ML eart | Approximati | e Interval |
| | Physician | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac of respiratory direct, such as caldiac of respiratory | | | | | | | | | | Between O Dea | | | |
| | ledical aminer | | Immediate Cause (Final dis or condition resulting in de- | sease a. Ciri | rhosis of Liver to (or as a conseq | uence of) | ١٠ | | | | | | | | | |
| | | | | h | to (or as a consequ | uerice or, |)· | | | | | | | | | |
| | | er | Sequentially list conditions if any, leading to immediate | e Due | to (or as a conseq | uence of |): | | | | | | | | | |
| | 1 | ımineı | cause. Enter Underlying C (Disease or injury that initial | ated "- | to (or as a conseq | uence of | ·): | | | | | | | | | |
| | nted d ansit | Exa | events resulting in death) | d. | | | | | | | | | | | | |
| V | executed ian and ial - transit | ical | UNPENDED | A | MENDED | | | | | | | | | | | |
| | , P.O. Box 68760, rest that the death certificate be executed signed by the attending physician and the death for use as the burial - (ransit). | Mec | UNPENDED IF FEMALE: | nt in the | 23c. If yes, outcome | e of pregr | | C-tal dooth | Ectop | ic pregnar | ncv | 1 | | d. Date of delivery Month Day Year | | |
| | Box 687 e death certific the attending p | Physician/ | 23b. Was decedent pregna past 12 months? | III III DIE | 1 Live birth Pregnant at ti | ime of de | | Fetal death Other (Specify) | | | | | | | | |
| | SOX leath cleath c | ysic | 1 Yes 2 No 9 | | g Unknown | | | | | | 100 5 | | | atributo to | the cause of | death? |
| | D. Entrine of | 占 | Part II. Other significant | conditions co | entributing to death | but not re | esulting in the | e underlying caus | e given in F | Part I. | | | | | bably 4 | |
| | P.O. | d b | | ism | | | | | | | | Was an | | Were a | utopsy finding | s available |
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| | tal Recision: The | Be C | | medical | | | | | Other | | | - D Pa | sidence | 6 Oth | er: | |
| | of Vital Records, ng Physician: The law require After this certificate has been s' | | 1 ✓ Yes 2 | No Hos | | | ER/Outpati | | Injury at Wo | | g Home 5 | | v injury occ | | | |
| | of ing Pl | Din: | 27. Manner of Death 1 ✓ Natural 5 | 7 - 4 | 28a. Date of Inju (Month, Day,Yo | ry ear) | 28b. Time | | Yes 2 | | | | | | | |
| | SiOr ttend death ctor: | atic | 2 Accident | Pending Investigation | 28a Place of In | iury - At h | nome, farm, s | street, factory, office | ce building, | etc. | 28f. Locat | tion (Stre | et and Nu | ımber or F | Rural Route N | umber, Cit |
| | Division tal or Attendirs after death. | Certification: | 3 Suicide 6 | Could not be determined | (Specify) | july 1 | | | | | or To | wn, Stat | e) | | | |
| | E 8 P. | | | | | y knowled | dge, death or | ocurred at the time | e, date and | place, and | d due to the | e cause(s | s) and mar | nner as st | ated. | |
| | the II hin 24 the F | Medical | (Check only one) 2 ✓ Medi | cal Examiner: C | n: To the best of m On the basis of examend manner stated. | mination | and/or invest | tigation, in my opi | mon, death | occan ca | at the time, | | | | | arl . |
| 4 | 5. iš € | S S | 29b. Signature and title of | | , Caraca | | | | ense numb | er | | | 29d. Date : Februar | | ∕ionth, Day, Ye ∩∩8 | ai) |
| 1 | J , | | h | \sim | h. | m | 3 | 0 | .C.M.E. | | | | repruar | y 13, 2 | | |
| | 1. | | 30. Name and address o | f person who co | ompleted cause of o | death (Ite | m 23a) | | m MD 0 | 1201 | | | | | | |
| | | | | | dical Examine | | | treet, Baltimo | ie, IVID 2 | . 1201 | | | | | | |
| | | Stat | | B 2 0 2 | 008 32. Remains | ar's Signa | ature | 1919 35 | | | | | | | | |
| | Reg | jistra | | - W W W | | | | | | | | _ | | CSSE | | |

Please Type or Print in Black Indelible Ink. Ensure Ali Copies Are Legible. 08-01316 State of Maryland / Department of Health and Mental Hygiene 2008 05023 Dale Rodney Jones Certificate of Death 1- For State Reg. No Registrar 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day February 15, 2008 1302 hrs Dale Rodney Jones Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** Sinai Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months Davs Hours 218-70-1959 Country) Sept. 22, 1959 Jirector Germany 48 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County any Baltimore 1 X Yes 2 No MD or 28a-f show imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

I file 27 is marked other than "natural", or items 23a or 28a-f shown or other traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number TISA 21201 819 West Saratoga Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Funeral 12. Was Decedent Ever in U.S 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 African American Yes 2 X No Specify Yes 2 X No specify: If Yes, Give Year Divorced \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) unk during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) q laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Alice Jackson Sterling Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4506 Cedar Garden Road; Baltimore, MD 21229 Phyllis Jones / Sister 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition timore, crematory or other place) Cremation 3 Removal from State 1 X Burial 2 02/22/2008 Baltimore, Maryland Mount Zion Cemetery Important: injury or ot Department 4 Donation 5 Other Specify: 22. Name and Address of Facility 21. Signature of Funeral Service License Wylie Funeral Home, P.A. 638 N. Gilmor Street: Baltimore, MD Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and **Physician** failure. List only one cause on each line Death /Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine rause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi sician/Medical AMENDED UNPENDED physician the burial -23d. Date of delivery 68760 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Live birth Fetal death 2 use as t past 12 months? Pregnant at time of Other (Specify) Box 1 Yes 2 No 9 Unknown ٥ Unknown ed by the a Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ö Yes 2 ✓ No 3 Probably 4 Unknown ے Completed 24b. Were autopsy findings available Records, 24a. Was an has been prior to completion of cause of autopsy death? performed? ✔ Yes 2 certificate 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Be of Vital Other4 examiner? Nursing Home 5 Residence 6 DOA 2 V ER/Outpatient 3 Inpatient this 1 V Yes No ۵ 28d Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury After 27. Manner of Death Subject shot by police Certification: Feb 15, 2008 Yes 2 ✔ No Division Pending hours after death. the Director: 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 4409 Fairview Avenue, Baltimore, MD 3 Could not be Suicide determined (Specify) Multi-Family Apt. 4 V Homicide To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Gertifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number Signature and title of certifier February 19, 2008 O.C.M.E. cause of death (Item 23a) 30 Name and address of person who o 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Laron Locke MD. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registra

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2 ERALDINE 35AM KITCHEN 2000 /Medical 4a. Facility Name (If not institution, give street and number)

Manor Care Health Services 4c. County Baltimore 4b. City, Town, or Location Ballistiore **Examiner** 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 29 Reiddedsland or Foreign 5. Social Security Number 6. Sex X 1 ☐ M 2X F **Funeral** 220-22-8609 Days Months Yrs. Director Usual Residence of Decedent 10b. County N/A Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. should be them 27 is marked other then "neturel; or Items 23e or 28e-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 27 is marked other then "neturel", or Items 23e or 28e-f show treumstic event, the Medical Examinar must be notified at Baltimore Marvland 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of the Quntry? 21207 1121 St. Agnes Lane Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forges? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. 11. Marital Status Black, White ack 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced | 1 | 16a. Decedent's Usual Occupation | Give kind of work done during most of working | life. DO NOT use reputation 15. Decedent's Education 16b. Kind of Business/Industry Nursing Home (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last)
Wendell Tavares 18. Mother's Name (First, MatticMaid avaicsne) Be P 19b. Mailing Astronomics and New Baltimere, RMaryland 21/207own, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eli Kitchen Husband permit. Pages 1 and Department of Health Importent: If Item 27 any injury or other tr <u>once</u>. 20a. Method of Disposition
1 S Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location of Gity Mills, Wille 02/21/08 Garrison Forest Veterans Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Namested Brothers Fruneral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 21. Signature of Funeral Service Licensee rugemy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or bear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CONGESTIVE MEARI /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by CHRONIC FIDNEY DISEAS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed 1 Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပို 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No after death. 2 Accident investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0059107 02-13-208 m.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS CENTER DRIVE REISTERSFOUN MD 21136 UMA 217

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 2 0 2008

32. Régistrar's Signature

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 16, 2008 Jagjit Kaur 1:05 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital 01ney Montgomery 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F Months Days Hours Director 213-23-0974 Oct 10, 1931 India Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. m 27 is marked other than "natural" or Items 23a or 28a.f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 📉 No Director Maryland Montgomery 01ney 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4413 Winding Oak Drive 20832 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Asian-Indian 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Singh Joginder Hanspa1 Harbhajan Kaur Hanspal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 4413 Winding Oak Drive Olney, Maryland 20832 Rajinder Babra/son permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other Once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 2/18/2008 Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. uanita Ryhomos 1411 Annapolis Road Odenton, Maryland 21113 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Days /Medical Due to (as a consequence of): Examiner Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as t attending | | for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 5 ☐ Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🏋 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0057630 Um, li 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Arun Anuradha, M.D. Prince Philip Drive Olney, Maryland20832 31. Date filed (Month, Day, Year) State Registrar 2008 FEB 2 0

DHMH 17 Rev 1/2001

Certificate of Death

KAHN

4b. City, Town, or Location of Death

2. Date of Death

FEBRUARY 15

and manner stated.

Registrar's Signature

and address of person who completed cause of greath (Item 23a) (Type, Print)

2008 0

3. Time of Death 10:15P ^M 2008 4c. County of Death BALTIMORE Birthplace (State or Foreign Country) MD 10d. Inside City Limits 1 □Yes 2 No 10g. Citizen of What Country? USA 14. Race - American Indian Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry OWN HOME FRIEDENBERG 20c. Location - City or Town, State BALTIMORE, MD Approximate Interval Between Onset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 1. Charles St. Balto. Md 21201

29a. Certifier

31. Date filed (Month, Day, FFB 2

Medical

State

Registrar

Physician

/Medical

Examiner

RUTH

4a. Facility Name (If not institution, give street and number)

6701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | 1 - For State Registrar | te of Marylan | | artment of H | | | iene () () | 8 05028 |
|---------------------|---|-----------------|---|---|--------------------------------|---|--|--|----------------------------------|---|
| | Dhusisi | | Decedent's Name (First, Middle, Last) | | | | | 2. Date of Deat Month | h Day | 3. Time of Death |
| | Physicia /Medic | _ | | Thomas E. | Kline | | | Februar | y 11 | 2008 9:42 A.M |
| | Examin | er | 4a. Facility Name (If not institution, give street a | nd number) | | | Location of Death | | 4c. County | of Death |
| | | | Harbor Hospital 5. Social Security Number 6. Sex | 7. Age (In yrs. I | last hirthday) | Baltin | IOTE If Under 24 Hrs. | 8. Date of Birth | N/A | Birthplace (State or Foreign |
| | Funeral Director | | 184 16 5295 | | Yrs. | Months Days | Hours Min. | (Month, Day, 09/28/1 | Year) | Country) Pennsylvania |
| | | | Usual Residence of Decedent | | | | | | 211 | |
| | show | _ | 10a. State 10b. County | | , Town or Lo | | | | | 10d. Inside City Limits 1 ☐ Yes 2 🖾 No |
| | 8e-f | Director | Maryland Anne Arun | del B | altimo | | | | | |
| | with ti | | 10e. Street and Number | | | 10f. Zip Code | | 1 | 0g. Citizen of V | |
| | eath | erai | 5218 Kramme Avenue 11. Marital Status 12. Wa | s Decedent Ever in U. | S. 13 V | | 225 ispanic Origin? (Si | pecify Yes or No- | U.S. | A . e - American Indian, |
| (0 | r then | Funerai | 1 Never Married 2 X Married 1 3 | ned Forces? Yes 2 □ No | | Was Decedent of H f Yes, specify Cuba | | Rican, etc.) | Blac | k, White, etc. |
| Ö | rel'. o | þ | 3 ☐ Widowed 4 ☐ Divorced If Y | es, Give ar or Dates: WW I | I | 1 ☐ Yes 2 🛣 No | Specify: | | Specify | . White |
| 5-0 | 72 ho | Completed | 15. Decedent's Education (Specify only highest grade comp | leted) | (Give | dent's Usual Occup | during most of wor | king | 16b. Kind of Bu | siness/Industry |
| 7 | vithin ne. han | mpi | | lege (1-4or 5+) | | <i>00 NOT use retired</i> nine Oper | | | Can Mar | nufacturing |
| io B | filed v Hygie ther t | | 9th 17. Father's Name (First, Middle, Last) | | Traci | THE OPER | | ne (First, Middle, I | | |
| Maryland 21215-0036 | d be ental ked o | To Be | Dennis Kl | line | | | | na Strass | | -, |
| 37 | shou ind M s mar umat | - | 19a. Informant's Name/Relationship (Type, Prin | nt) | 19b. Mailir | ng Address (Street | | | | State, Zip Code) |
| Š | and 2 | | Lois Bohdal / Daugh | nter | 436 (| Obrecht R | oad M | illersvil | lle, Mai | ryland 21108 |
| ore | of He of He fitern roth | | 20a. Method of Disposition 1 1 Burial 2 □ Cremation 3 □ Remova | | lace of Dispo emetery, crer | sition (Name of natory or other place | Θ) | Date | 20c. Location - | City or Town, State |
| Ĕ | Pag ment tent: I | | ' 4 ☐ Donation 5 ☐ Other (Specify) | Gle | | | | 16/2008 | Glen Bu | rnie, Maryland |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "naturel", or itema 23a or 28e-f show eny injury or other treumatic event, if a Neulcul Ever-il air trust be neithed at once. | | 21. Signatu of Fundral Service Licensee | hudge | 40 | Name and Address | ie Highwa | av Balti | imore. N | rvice, P.A. Maryland 21225 |
| | | | 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus | that caused the death | n. Do not ent | er the mode of dyin | g, such as cardiac | or respiratory arre | est, | Approximate Interval Between |
| | Physician | ë ly | Immediate Cause (Final disease or condition | Myocardi | al 1 | nfarchio | n | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | | 4 | | | | | |
| | | - La | Sequentially list conditions, if my k and immediate cause. Enter Underlying | Due to for as a consequence | | | | | | |
| / | uted d ansit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | |
| V, | exec an an | Еха | | ue to (or as a consequ | uence of): | | | | | |
| 8760, | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit | dicai | d | | | | | | | |
| 9 | artifica ing pt e as t | Med | IF FEMALE: | | | | | | | |
| Вох | eath certific attending p | lan/ | 23b. Was decedent pregnant in the past 12 months? | es, outcome of pregna Live birth 2 Fetal | ldeath 3□ | Ectopic pregnancy | | | 23d. Dat Mo | e of delivery nth Day Year |
| О. О. | that the de ed by the a detached t | ysic | | Pregnant at time of de Unknown | eath 5L | Other (specify) | | | | |
| σ. | that hed by deta | by Physician/Me | Part II. Other significant conditions contributing | ig to death but not resi | ulting in the u | nderlying cause giv | en in Part I. | 23e. Did tol | oacco use conti | ribute to the cause of death? |
| rds | n requires been sign should be | | | | | | | 1 🗆 Ye | es 2 🗆 No | 3 Probably 4 Monknown |
| Vital Records, | law requas been 2 should | Completed | | | | | | 24a. Was a autops | | Were autopsy findings available prior to completion of cause of |
| Ĕ | The I | mox | | | | | | perforr | ned? | leath? |
| /ita | ysician: Th is certificate director, pag | Be (| 25. Was case referred to medical examiner? | | | | | th (Check only on | e) | |
|)) | dis ys | ď | 1 Yes 2 No Hospital | 1 Linpatient 2 L | ER/Outpatier | | 4 Nulsing n | ome 5 Reside | | |
| Division of | ding F h. After funera | ion: | 1 ☑Natural 5 ☐ Pending | . Date of Injury (Month, Day Year) | 28b. Time of Injury | Wor | yat k? Yes 2∐No | 28d. Describe ho | ow injury occurr | ea |
| <u> S</u> | t or Attending Physician: after death. Director: After this certifici i in by the funeral director. | fical | 3 Suicide 6 Could not be | . Place of Injury - At ho | ome, farm, str | | .03 2 | | | er or Rural Route Number, |
| 2 | i tte | Certification; | 4 Homicide | building, etc. (Specify | y) | | | City or Town | n, State) | |
| | To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in | Medical (| 29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: Or an | To the best of my kno the basis of examina d manner stated. | wledge, deat tion and/or in | n occurred at the tin vestigation, in my o | ne, date and place pinion, death occu | , and due to the carred at the time, d | ause(s) and ma ate and place, | nner as stated. and due to the cause(s) |
| | To the within To the Comple | Me | 29b. Signature and title of certifier | 7 | | 29c. Licens | e number | 2 | 9d. Date signed | 1 (Month, Day, Year) |
| | | |) Ohandelwas | ans | | Dol | 052490 | 0. | 2/19/08 | 3 |
| 6 | +1 | | 30. Name and address of person who complete Anita Khana | d cause of death (Item | 23a) (Type, | Print) | 'an ova - | St. B41 | home | MD 21225 |
| | Sta Registr | | | Registrar's Signa | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 10:15 p ^M Dorothy Estelle Little Feb 14, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Overlea Health and Rehabilitation Baltimore Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🖾 F Director 216-28-9499 MD 08-17-1927 80 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10a. State 10b. County 1 ✓ Yes 2 ☐ No Director BAUTIMORE MD Baltimore 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with t Hygiene. "natural", or Items 23a 21237 USA 1227 Primrose Ave. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: White Specify: 3 NWidowed 4 □ Divorced the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event Be Estelle Keller Robert McCoy 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman Tippett 1227 Primrose Ave. Baltimore MD 21237 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 02-18-2008 | Baltimore MD Gardens Of Faith 22. Name and Address of Facility Schimunek Funeral Home Inc. 21. Signature of Funeral Service Licensee 9705 Belair Road Nottingham MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical andiac Failure Examiner 5-quantially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed burial-trar Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No fo Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ed by t detach signed b significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an has page 2 certificate 1☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this After th funeral 27. Man fer of Death 28c. Injury at Work? 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred Medical Certification: 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Box 68760, P.0. Division or Vital Records, or Attending To the Hospital

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State

29a. Certifier (Check only one)

29b. Signature and title of certifier

31 Day filed (Month, Day, Year)

Registrar

1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Warpha Sange, 821 N. Ewlaw Theet, #308, Baltimore, MD2(20)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Amend 18, 20a-c, &22, perFH, 0876, 2/20 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** nd 1002 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 40. County of Death Examiner atonsv H124 8. Date of Birth (Month, Day, Year) Aug 19, 1926 Age (In yrs. last birthday) 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign **Funeral** Months Virginia 1 ☐ M 2 🕱 F Aug Director 220-24-4414 81 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Catonsville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 1502 Frederick Road death v Funeral permit. Pages 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or the any injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2X No black Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) housekeeper private residences 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WIlliam Lindsey Ruth Barnes ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Henderson/son 545 N. Carey Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1**X** Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 IX Other (Specify) 3 □ Removal from State ei 2/22/2008 Dundalk 22 Name and Address of Facility Wesley Chavis F.H. 2 State Anatomy Board 55 W. Ballin in state Mt. Carmel 21. Signature of Euneral Service Licensee Ronal Service Warte Director 21201 21231 Baltimore, MD 23a. Part. Enter the diseale, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate vause (Final disease or condition resulting in death) **Physician** Foulure /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed signed by the attending physician and the detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 24a. Was an autopsy 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 Yes 2 You Be 26. Place of Death (Check only one) Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) . Manner of Death Watural 2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury a Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Tyes 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1116cn 31. Date filed (Month, Day, Year) FEB 2 0 2008

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Year **Physician** Law 65 Coral 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Howard County General Hospital Columbia 8. Date of Birth (Month, Day, Year) 4,1952 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Rhode Island 55 038-34-7949 Director Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 10b County show ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Columbia Director Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21045 U.S.A. 9706 Basket Ring Road by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. within 72 hours after 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within ealth and Mental Hygiene.
n 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Manager Food Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louise Brothers George Harry Law, Sr. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Victoria Tapley · Sister 167 Prudence Ave Providence, Rhode Island 20909 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rhode TSTand Veterans Memorial Cemetery 2-18-2008 Exeter, RI 22. Name and Ad ress of Facility
Witzke Funeral Homes, Inc 21. Signature 1 Funeral Service 5555 Twin Knolls Road death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final 2 L **Physician** sho c TIC disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner Nemus Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Mass attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

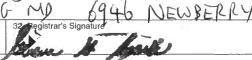
1 ☐ Yes 2 DNo 24a. Was an page 2 s autopsy perform 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) No No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a e Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (T

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State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)
FFB 2 0 2008



DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23a Per Phy G8/62/20/08 JH Gertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** MACDONALD Februar 540 AM CARTER 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOJPITAL RANGALLSTONN BALTIMORE WORTHWEST If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug • 5, 1924 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 □ F Maryland 83 Aug. 219-16-9155 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location show 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes Ž☐ No Director Maryland Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Sunnyking Dr. 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Apped Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical once. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Milkman Cloverland Dairy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Homer G. MacDonald Wanda Lee Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James MacDonald - son P.O. Box 51, Glyndon, MD. 21071 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 IX Cremation 3 ☐ Removal from State Metro Crematory Feb. 18,2008 Baltimore, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lckhardt Funeral Chapel F.A. 11605 Reisterstown Rd. Owings Mills, Md. 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Myeloid Leukemia **Physician** /Medical Due to (or as a consequence f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) that the death certificate be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760, physician s the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an page 2 s has autopsy performed 2**⊠** No certificate 1□ Yes 2 X No Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☑ No 1☑Inpatient 2☐ER/Outpatient 3☐ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending (Month, Day Year) 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No thours after death.

uneral Director: A death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af

To the Funeral D

completely filled i Medical 29a, Certifier 1'☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Patruh

WATION

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MZPAT 124 LK.

32. Registrar's Signature

DHMH 17 Rev 1/2001

DO05 9736

HOJPHAL

NORTHWEST

5401

2009

COURT RUAD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 📗 🗎 🖁 1- State Registrar Amend 20a, perFH, g876, 2/20/08 TTCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician MOFFA Year 6-45 AM Phryory 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mursina altimore Ball ayen If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Director 077-18-4899 84 Yrs. 4-10-1923 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at Cit 1 Yes 2 No Director Balt Bultimore M.D 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? ö 238 usn AVE 21215 Funerai nharst 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status I ☐ Yes 2 ♣No f Yes, Give Year or Dates: 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify δ 3 ₩ Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secratary OFFICE UNK unk permit. Pages 1 and 2 should be fite Department of Health and Mantal Hy Important: If item 27 is marked oth any liqury or other traumatic event size. 18. Mother Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Richard Unk unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department 25 haze

20b. Place of Disposition (Name of cometer), gramatory or other place)

References

References Calvert Z1202 Freida Jone Room 300 20a. Method of Disposition 20c. Location - City or Town, State 3 Removal from State 19-2008 4 ☐ Donation 5 ☐ Other (Specify) Ball 21. Signature of Funeral Service Licensee Hudson st 22. Name and Address of Facility 2829 Ball. MD ZIZZY 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Skarder Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. A les o sclerco 90 ear /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to for as a consequence of Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and ed by the attending physicien and detached for use as the burial-transit Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ② Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No r: After this certifical funeral director, r Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 🕱 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No I Director: A sid in by the fi investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 & Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the date (c) and manner at ctated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) Amstyn W Maan 30. Name and address of person who completed cause of death (Item 23a) (Free Print) AMATUN NAEEIN 501 Definin Street Registrar's Signature 31. Date filed (Month, Day, Year) FEB 2 0 2008 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4b. City, Town, or Location of Death Examiner Towso Baltmor for Hospice are If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 ☑ F Days Hours West Inde Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State ıral", or items 23a or 28a-f show I Exaπlner must be notlfied at 1 ☐ Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 271 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Black ģ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hyg Item 27 is marked other 18. Mother's Name (First, Middle, Ma 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name/Relationship (Type. Print) 20a. Method of Disposition permit. Pages
Department of I
Important: If ite
any Injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatule of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 45ARS Physician resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 X No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2□ No 1 Yes 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Certification: To 1 ☐ Yes 200No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 264395 FEBRUARY 15, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 N. CHARLES ST, SUITE 209 BALTIMORE, MD 21204 DANIEUE DOBERMAN, MO 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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| | | | For | State of Ma | arylan | | partment of H | | Mental Hy | giene) n n 8 | 05036 | | |
| | | | State Registrar | | | Ce | ertificate of | Death | | Reg. No. | 00000 | | |
| | ysicia Medic | | Decedent's Name (First, Middle, Last ELLSWORTH FRANKLI | | , 4T | Н | | | 2. Date of De. TEBRUA | | 3. Time of Death | | |
| | amin | er | 4a. Facility Name (If not institution, give | 4c. County of De | eath | | | | | | | | |
| | | | 5. Social Security Number 6. S | HUNE H | RUNDE L Birthplace (State or Foreign | | | | | | | | |
| Fund Direct | | | | ∑ M 2□F | 46 | ast birthda Yrs. | Months Days | Hours Min. | FEB • 2 | 7, 1961 MA | Country) | | |
| yland | aţ | | 10a. State 10b. County | | 10c. City | , Town or I | Location | | | · · · · · · · · · · · · · · · · · · · | 10d. Inside City Limits | | |
| e Mar Ba-f sl | tiffied | Director | MARYLAND ANNE ARU | NDEL | GLE | N BUR | | | | | 1 ☐ Yes 2X No | | |
| with th | pe no | Dir. | 10e. Street and Number | ת | | | 10f. Zip Code | | | 10g. Citizen of What | | | |
| eath | must | Funeral | 17 SUMAC RD., APT | 12. Was Decedent | Ever in U. | S. 13 | 21060 B. Was Decedent of H | lispanic Origin? (St | pecify Yes or No | UNITED ST | MTES merican Indian, | | |
| IOTE, IMARYIANG 21213-UU36 ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show | xaminer | by Fun | 1 ☐ Never Married 2☐ Married 3 ☑ Widowed 4 ☐ Divorced | Armed Forces? 1 ☐ Yes 2 🐧 I If Yes, Give Year or Dates: | | If Yes, specify Cuban, Mexican, Puerto Ricar | | | | Black, W Specify: WH | | | |
| 5-0036 72 hours af "natural", or | calE | | 15. Decedent's Ed | lucation | | 16a. Dec | edent's Usual Occup | pation | tala a | 16b. Kind of Busine | | | |
| within 7 iene. | Med | Completed | (Specify only highest gra Elementary/Secondary (0-12) | College (1-4or 5 | +) | | ve kind of work done DO NOT use retired | • | Kirig | | | | |
| filed w Hygier | ıt, tbe | ပ္ပ | 17. Father's Name (First, Middle, Last, | 4 | | ELEV | ATOR INSTA | | na (Firet Middle | ELEVATOR Maiden Surname) | | | |
| id be file ental Hy ked oth | ever | Be | ELLSWORTH FRANKLI | | 2101 | n | | | , | , <i>maiden sumame)</i> LE WHITAKE | D | | |
| aryla should and Men s marke | rmati | 은 | 19a. Informant's Name/Relationship (| | <u>ا۸</u> کـ و | | iling Address (Street | | | er, City or Town, State | | | |
| and 2 sealth an n 27 is i | er tra | | E. CAROLE MARSHAL | L / MOTHER | | 8249 | BODKIN AV | JE., PASA | DENA, MA | ARYLAND 21 | 122 | | |
| Saltimore, permit. Pages 1 ar popurant: If item | r oth | 1 | 20a. Method of Disposition 1 ☐ Burial 2 🌣 Cremation 3 ☐ | Removal from State | 20b. P | lace of Dis emetery, cr | position (Name of rematory or other plac | ce) FEB | Date 21, | 20c. Location - City | or Town, State | | |
| Baltimory permit. Pages Department of H Important: If ite | yinny | | 4 ☐ Conation 5 ☐ Other (Specif | y) | MET | | EMATORY, | INC. 2 | 008 | CATONSVIL | LE, MARYALND | | |
| Dermi Depar | any lr | | 21. Signature of L. neral Service Licer | Ne | | 1 | 22. Name and Addre | JDDICK FU | NERAL HO | OME, P.A. N BURNIE, | am 01061 | | |
| | 77 | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that caused | the death | | | | | | Approximate Interval Between | | |
| Physic | ian | | Immediate Cause (Final disease or condition | one cause on each in | AR | ice | AL R | وأوجون | 16 | | Onset and Death | | |
| /Medi | ical | | resulting in death) | Due to (or as | a consequ | uence of): | | u v - | | | | | |
| Exami | ner | _ | Sequentially list conditions, | b | INA | 20 | ac 3 | PUALO | Lyins | | | | |
| / pet | nsit | Examiner | Sequentially list conditions, if any, leading to intrinculate cause. Enter Underlying Cause (Disease or injury | Due to (or as | 1 = 5 | s: 0 1 | + run | 45572 | 1-75 | | | | |
| executed in and | ial-tra | Еха | that initiated events resulting in death) Last | Due to (or as | a consequ | uence of): | , - , | 015110 | | | | | |
| BOX 68 / 60, eath certificate be executed attending physician and | he bur | ical | | _ d | | | | | | | | | |
| oertificate ding physic | e as t | Medica | IF FEMALE: | 00 1/ | | | | | | | | | |
| death cer e attendir | for us | Physician/M | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome 1□Live birth 4□Pregnant a | 2 Feta | I death 3 | B Ectopic pregnanc | у | | 23d. Date of Month | delivery Day Year | | |
| the de | ched | ysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9□Unknown | time or a | oaiii c | omer (apecity) | | | | | | |
| w requires that the debeen signed by the | e deta | by P | Part II. Other significant conditions | ontributing to death b | ut not resu | ulting in the | underlying cause giv | ven in Part I. | 23e. Did t | | e to the cause of death? | | |
| ecord law require as been sign | ould | | - | | | | | | | 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown | | | |
| a a | e 2 sh | Completed | | | | | | | 24a. Was auto | an 24b. Were prior death | autopsy findings available to completion of cause of | | |
| VITAI HO | r, pag | | OF Wee consistent to medical | | | | | | 1□ Yes | 2 1 No 1 N | res 2 No | | |
| Or VITA Physician: | director, | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: 1 Tippatie | ent 2∏ | ER/Outpati | ient 3 DOA Oth | 26. Place of Dea | | one) idence 6 □Other (S | Specify) | | |
| - 0 | neral o | \vdash | 27. Manner of Death | 28a. Date of Inju | ry | 28b. Time | of 28c. Inju | | | how injury occurred | poony | | |
| IVISION or Attending ter death. irector: After | he fur | atio | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation | 1 | , , , , | | | Yes 2 □ No | | | | | |
| 4 0 | 2 | Certification: | 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined | 28e. Place of inj building, et | ury - At ho c. <i>(Sp</i> ec <i>if</i> | ome, farm, : | street, factory, office | | 28f. Location (City or To | Street and Number or wn, State) | r Rural Route Number, | | |
| DIN To the Hospital or within 24 hours after To the Funeral Dire | filled | Ce | 29a. Certifier 1 Certifying Pi | vsician: To the best | of mv kno | wiedae, de | ath occurred at the ti | ime, date and place | e, and due to the | cause(s) and manne | r as stated. | | |
| To the Hospital within 24 hours a | letely | edical | | | f examina | | | | | , date and place, and | | | |
| To th To th | сошр | Me | 29b. Signature and title of contifier | - () | | | 29c. Licens | | | 29d. Date signed (M | | | |
| | | | 13 | CU- | | | 10 | 05376 | 03 | Februa | no 18, 2008 | | |
| (0 | | | 30. Name and address of person who | completed cause of c | eath (Item | 1 23a) (Typ | e, Print) | ican. | - WARY | 1 Com | 942NIEMA | | |
| | Sta | te | BACIMON 31. Date filed (Month, Day, Year) FEB 2 0 2008 | 32. Registr | ar's Signa | iture | 12 n | | | - Gui | JUI-7-10 1 2 | | |
| Re | gistr | ar | FEB 2 0 2008 | A STATE OF | 300 E | | A. C. | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 17 Year 2150 M February James I. Murray, Jr. 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Days Months 1 M 2 □ F 214-80-7468 48 08-09-1959 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 813 Vale Rd 21014 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married ☐ Yes 2 No f Yes, Give 1 ☐ Yes 2 No Specify:White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James I. Murray, Sr. Marietta Carmen Bruno 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Theresa Murray (Wife) 813 Vale Rd Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Highview Memorial 02-21-2008 Fallston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 21. Signature of Funeral Service Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebro vascula days Due to (or as a consequence of): Adveno Corcinoma Esophageal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) e pf pregnancy 23d. Date of delivery 2 🗌 Fetal death 3 Ectopic pregnancy Month Day at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? nown able

Physician /Medical Examiner

permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If Item 27 Is marked of any Injury or other traumatic eve

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edi al Examiner must be notifled at

the Medical

Director

Funeral

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Completed

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should be filed within 72 hours after death with the Maryland of Mental Hygiene.

marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

burial-tran physician the l as use for ed by the a signed b certificate has I page

law requires that the death certificate be executed

Physician:

or Attending

To the Hospital

within 24 hours after death.

To the Funeral Director: /

the

in by 1

filled

Medical

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical ģ Completed Be ပို After this Certification:

| FEMALE: 8b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcom 1 □Live birth 4 □ Pregnant 9 □ Unknown |
|---|---|
| | |

24

| | 1 🗆 Y | es 2[|] No | 3 ☐ Pro | bably | 4 Unkn |
|------|---------------------|-------|------|-------------------|-------|-----------------------------|
| 24a. | Was a autops perfor | sy | | | | idings avail on of cause |
| 10 | Yes | 2 No | | death? 1 ☐ Yes | 2)251 | No |

28f. Location (Street and Number or Rural Route Number, City or Town, State)

| examiner? | |
|---------------------|---------|
| 27. Manner of Death | |
| 1 Natural | 5 Pendi |
| 2 Accident | invest |

Pending investigation 6 Could not be determined

Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury 28b. Time of (Month, Day Year) Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death Check onl one

29a. Certifie (Check only one)

3 ☐ Suicide

4 Homicide

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month. Dav. Year) 2008

Registrar

31. Date filed (Month, Day, Year)

FEB 2 0

3 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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| | | | For State Registrar | - | artment of Health and M rtificate of Death | 1ental Hyglen Reg. N | 2002 05038 |
|----------------------------|---|----------------|--|---|--|--|---|
| £ | Physici | _ | 1. Decedent's Name (First, Middle, Last) BLANCHE | mco | CORMICK | 2. Date of Death Month D FERRUSA | ay 7 Year 11:30 AM |
| | /Medic Examin | and the | 4a. Facility Name (If not institution, give street a | and number) | 4b. City, Town, or Location of Death | . 4 | c. County of Death |
| | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. last birthday) | MILLERS VILLO If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | To Date of Dinte | ANNE ALUNDER 9. Birthplace (State or Foreign Country) |
| D | Director | | 2:27-40-9930 1 M 2 Usual Residence of Decedent | 1 / | | MEBRUARY. | Country (State or Foreign Country) |
| | // Aarylan f show ed at | or | 10a. State 10b. County MD ANNE ARU | 10c. City, Town or Lo | | | 10d. Inside City Limits 1 ☐ Yes 2 No |
| | th the lor 28a- e notifi | Director | 10e. Street and Number | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 10f. Zip Code | 10g. C | citizen of What Country? |
| | eath wi | Funeral L | 1326 HOWARD 11. Marital Status 12. Wa | | 21061 Was Decedent of Hispanic Origin? (Sp | | 9NITE) STATES 14. Race - American Indian, |
| 036 | be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 23a-f show event, the Medical Examiner must be notified at | | 1 Never Married 2 Married 1 If N | TYes 2 Tel No | Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 (No Specify: | Rican, etc.) | Black, White, etc. Specify: CAUCASIA-N |
| 21215-0036 | n 72 ho r "natur ledical | leted | 15. Decedent's Education (Specify only highest grade comp | leted) (Give | dent's Usual Occupation kind of work done during most of work DO NOT use retired) | ing | Kind of Business/Industry |
| | ed withi ygiene. ner thar t, the N | Completed by | 12 | llege (1-4or 5+) | LIBRARIAN | | ERU SPACE |
| Maryland | be pd o | To Be | 17. Father's Name (First, Middle, Last) TAMES PAU | L EAKIN | AIDA | e (First, Middle, Maide MARI C | 4 / / |
| Mary | 2 sh and Is m | | 19a. Informant's Name/Relationship (Type. Pr. JOHN M. CORMICIO | · • | ng Address (Street and Number or Rui | | OF TOWN, State, Zip Code) TN BULNIE MO 2106 |
| _ | es 1 and of Health fitem 27 rother tu | | 20a. Method of Disposition | 20b. Place of Dispo | | Date 20c. | Location - City or Town, State |
| Baltimore , | t. Pag rtment rtant: I | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify) | mo state | ANATOMY BD | | ALTIMORE, MD |
| Ba | permi Depar Impo any Ir once | | 21. Signature of Europea Service Licensee ROnald S Wad | B | tlare akadesayaabbaro altimore, MD 2120 |)1 | altimore Street |
| ı | | | 23a. Part I. Enter the disease, or complication shock, or heart failure. List only one cau | | | | Approximate Interval Between Onset and Death |
| | /Medical | | resulting in death) | Due to (or as a consequence of): | OTIC CARDION | ASCULA | 12 DISCHSU YGAR |
| | Examiner | er | Sequentially list conditions, b. | Due to (or as a consequence of): | | | |
| | recuted and -transit | Examiner | i any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of): | | | |
| 68760, | icate be executed physician and s the burial-transit | edical E | d | 510 to (6) do d 00/100425/100 0// | | | |
| _ | | /Med | IF FEMALE: 23c, If 1 | res, outcome pf pregnancy | | | 23d. Date of delivery |
| P.O. Box | es that the death cer igned by the attendir be detached for use | Physician/M | in the past 12 months? | Live birth 2 Fetal death 3 | □Ectopic pregnancy □ Other (specify) | | Month Day Year |
| rds, P | quires that n signed build be deta | by | Part II. Other significant conditions contribute | ng to death but not resulting in the u | underlying cause given in Part I. | | o use contribute to the cause of death? 2★No 3□ Probably 4□Unknown |
| Division or Vital Records, | To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after dea h. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | Completed | | | | 24a. Was an autopsy performed? 1 Yes 2 ■ | 24b. Were autopsy findings available prior to completion of cause of death? |
| Vita | hysician: The Is his certificate has I director, page 2 | o Be C | 25. Was case referred to medical examiner? 1 □ Yes 2 No Hospita | ıl: 1 | Lau - | th (Check only one) ome 5 Residence | |
| n or | ng Phy (fter this Ineral d | | | a. Date of Injury (Month, Day Year) 28b. Time of Injury | of 28c. Injury at Work? | 28d. Describe how in | |
| ivisio | To the Hospital or Attending Ph within 24 hours after dea h. To the Funeral Director: After th completely filled in by the funeral | Certification: | 2 Accident investigation | p. Place of injury - At home, farm, st building, etc. <i>(Specify)</i> | M 1 ☐ Yes 2 ☐ No creet, factory, office | 28f. Location (Street City or Town, Sta | and Number or Rural Route Number, ate) |
| | To the Hospital within 24 hours To the Funeral completely filled | ical | (Check only 2 Medical Examiner: C | n the basis of examination and/or in | th occurred at the time, date and place nvestigation, in my opinion, death occu | rred at the time, date a | and place, and due to the cause(s) |
| | To the within 2 To the comple | Med | 29b. Signature and title of certifier | A A A A A | 29c. License number | 29d. I | Date signed (Month, Day, Year) |
|) | | | 1 On Ciwa | Clair Mi) | D3/136 | FE | BRUARY 11, 2008 |
| | 11 | | 29b. Signature and little of certifier 30. Name and address of person who complet BR (AN C - WALL 31. Date filed (Month, Day, Year) FEB 2 0 2008 | ACE, MD, GOO | 5 KILBRIDE F | 20, BATI | MORE MAD 21236 |
| | Sta Regist | ite rar | 31. Date filed (Month, Day, Year) FEB 2 0 2008 | 32/Registrar's Signature | arte | / | |

08-01401 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Miguel Rafael Portocarrero State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day February 18, 2008 Medical Examiner Miguel Rafael Portocarrero Miranda 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Woodstock 10749 Folkestone Way Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Director Sept.14, 1945 1 X M 2 F 62 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the <u>Medical Examiner must be notified at once.</u> Caracas jes 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Miranda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Calle C Edif. Iris Mar PH2 1080 Venezuela 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 X Married Yes 2 X No 1X Yes 2 No specify: Venezuelan Widowed Divorced If Yes, Give Year ģ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 5+ Accountant Accounting 17, Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Luis Portocarrero Zoraida Miranda 8 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt: If item 27 ir r other traumat Miguel Rafael Portocarrero-Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Pages 1 nent of F Burial 2 Cremation 3 X Removal from State Donation 5 Other Specify 21. Signature of Funeral Service Lie ise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the **Physician** failure. List only one cause on each line. /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical the attending physician ed for use as the burial -UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð npleted this certificate has been a director, page 2 should 24a. Was an autopsy performed? Com To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA P 1 ✓ Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 V Natural Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier (Check only

10749 Folkestone Way; Woodstock, MD 21163 20c. Location - City or Town, State Caracas, Venezuela 22. Name and Address of Facility Sterling Ashton Schwah Witzke Funeral Home of Catonsville, Inc. Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ✔ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Yes 2 V No 2 No Nursing Home 5 Residence 6 ✔ Other: Scene 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 18, 2008 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 ÖRIGINAL

05039

3. Time of Death

0806 hrs

Foreign CountryWenezuela

Race - American Indian, Black.

White, etc.

Specify: White

10d. Inside City Limits 1 Yes 2 XNo

2008

State Registrar

31. Date filed (Month, Day, Year FEB 2 0 2

OCME

29b. Signature and title of certifier

Ana Rubio MD.

32. Registrar's Signature

| 08-00848 Yarnell Ralph Mc | 1 | ght, Jr. S - For State | pe or Print in tate of Marylar | nd / Depai | rtment o | Ink. Ensure of Health and of Death | e All Cop d Mental | ies Are Legi Hygiene Reg. | 201 | 3. Time of Death |
|---|-----------------|---|--|---|------------------------------|---|---------------------------------|---|----------------------------------|---|
| Physicia Medical Examin | n/ | 1. Decedent's Name (First, Midd Yarnell Ral | ay Year 2008 | 1423 hrs | | | | | | |
| Weulcai Examin | | 4a. Facility Name (if not instituti | | | | 4b. City, Town, or | | | 4c. County of Dea Washington | eth |
| | | 820 Lanvale Street | To 0 | 7. Age (In yrs. Ia | ot hinthday) | Hagerstown | | Hrs. 8. Date of Birth | (MM/DD/YYYY) 9. E | Birthplace (State or |
| Funeral Director | | 5. Social Security Number 187–54–4203 | 6. Sex | | | Months Day | | Sept 2 | Fore | eign Country) PA |
| aus | - | Usual Residence of Decedent 10a. State 10b. County | / | 10c. City, | Town or Loc | cation | | | | 10d. Inside City Limits |
| * | ٦ | MID Was | shington | H | lagers | town | | | | 1 Yes 2 X No |
| Maryla 28a-f | Director | 10e. Street and Number | | | | 10f. Zip Code | | 10g | . Citizen of What Co | ountry? |
| The OS or reach with the Maryland or items 23a or 28a-f show must be notified at once. | | 820 Lanvale S | | edent Ever in U. | S. 13. V | 217 Was Decedent of Hi | | (Specify Yes or No- | | nerican Indian, Black, |
| cath w | Funeral | 1 Never Married 2 | _ | | ' | f Yes, specify Cuba | n, Mexican, Pue | erto Rican, etc.) | White, etc | |
| after d | by F. | | ivorced If Yes, Give Year or Dates: | | - | Yes 2 X No | | of work done | Specify: 16b. Kind of Busines | Black |
| hours 'natur Exami | | 15. Decedent's Education (Sp | | | 16a. Deced during | most of working life | e. DO NOT use | | TOD: TAILE OF EASITION | 1 |
| 136 thin 72 se. than ' | Completed | Elementary/Secondary (0-12 | ., | , | | | Student | | | cation |
| 5-0(lled wi Hygier I other the M | | 17. Father's Name (First, Midd | | ± C | | | | ame (First, Middle, M | | |
| Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. | To Be | Yarnell Ral | | it, Sr. | 19b. Ma | iling Address (Stre | et and Number | or Rural Route Numb | er, City or Town, Si | tate, Zip Code) |
| VD 2 2 shou 2 shou h and 7 27 is umatic | ۲ | Yorlondo Wort | | er) | 118 | 50 New Co | untry I | ane Colu | nbia, MD 20c. Location - City | 21044 |
| re, P s.1 and f.Healt f.item er tran | | 20a. Method of Disposition 1 X Burial 2 Cremat | on 3 Removal fro | om State | crematory of | position (Name of c r other place) | i | Date | | |
| imo Pages ment or tant: I | | 4 Donation 5 Other | Specify: | Me | | idge Memo | | rk 2/9/08 | Elkridg | e, MD |
| Baltimo permit. Page Department of Important: injury or oth | | 21. Signature of Funeral Servi | \ | 00053 | 1.0 | Garw I. K | aufman | Funeral Ho | ome at MM | P, Inc. |
| · Physician | | 23a. Part I. Enter the disease, failure. List only one cau | or complications that co | aused the death | n. Do not ent | er the mode of dyin | g, such as card | ac or respiratory arre | st, shock or heart | proxi te Interval Between Onset and |
| /Medical :aminer | | Immediate Cause (Final disea | se a. Coronar | | | sis | | | | Death |
| Jummer | | or condition resulting in death | | consequence of | | vascular di | sease | | | |
| | Jer | Sequentially list conditions, if any, leading to immediate | Due to (or as a | consequence | | | | | | |
| cuted md transit | Exami | cause. Enter Underlying Cau (Disease or injury that initiate events resulting in death) Las | Due to for on a | consequence (| of): | | | | | |
| | lical | X UNPENDED | | a-b. 27 | . perME | ,g876, 2/21 | /08 TT | | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions. | Physician/Medic | IF FEMALE: 23b. Was decedent pregnant i past 12 months? 1 Yes 2 No 9 | n the 23c. If yes, | outcome of pre- pirth nant at time of d | gnancy 2 | Fetal death Other (Specify) | Ectopic p | | 23d. Date of de Month | Day Year |
| Division of Vital Records, P.O. B rat or Attending Physician: The law requires that the d is after death. In Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached | by Phy | Part II. Other significant cor | ditions contributing t | o death but not | resulting in | the underlying caus | e given in Part | | | te to the cause of death? Probably 4 Unknown |
| ds, lequires | eted | | | | | | | 24a. Was | an 24b. We | re autopsy findings available or to completion of cause of |
| e law r e has b ge 2 sh | Completed | | | | | | | | rmed? dea | ith? Yes 2 No |
| il Re in: Th rtificat tor, pag | ပ္စိ | 25. Was case referred to med | tical | | | 26.Pla | ice of Death (C | | | |
| Vita hysteia this ce | <u>m</u> | examiner? 1 ✓ Yes 2 No | Hospital: 1 | Inpatient 2 | ER/Outpa | | | | Residence 6 🗸 | |
| 1 of ling Pl After funera | l H | 27. Manner of Death 1 v Natural 5 | (Mont | e of Injury th, Day,Year) | 28b. Time | · | njury at Work? Yes 2 N | | now injury occurred | |
| Division Hospital or Attend 24 hours after death 25 thours after death stely filled in by the 1 | Certification: | 2 Accident | Pending nvestigation 28e. Pla | ce of Injury - At | home, farm, | street, factory, office | e building, etc. | | | or Rural Route Number, City |
| Divi | erti | 4 Homicide | etermined (Specify |) | | | | or Town, S | | |
| Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | Medical C | 29a Certifier | g Physician: To the be Examiner: On the basis and manner | of examination | edge, death and/or inve | occurred at the time stigation, in my opin | , date and plaction, death occu | e, and due to the causurred at the time, date | and place, and due | to the cause(s) |
| To To con | Ĭ Š | 29b. Signature and title of ce | | / | | | ense number | | 1 | (Month, Day, Year) |
| 9 | | / // | / V | 1 | | 0. | C.M.E. | | January 31, | <u></u> |
| OCME | | 30. Name and advess of Mary G. Ripple MD | | use of death (Ite Medical Ex | _{em 23a)} aminer | 111 Penn Stre | eet, Baltimo | re, MD 21201 | | |
| | tat | 31. Date filed (Month, Day, Yo | ear) 32. F | Reg Lar Signa | ature | free B | | | | |
| Regis | stra | 4 <u>FE</u> E | 2 0 2000 | No. of Street, or other Persons | 0000 | 4 | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav 7:15 A M BRIAN COOPER MOFFETT SR. 15, FEBRUARY 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Joppa If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) Months 1 XM 2 1 F 213-60-5598 52 Apr. 3, 1955 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland | Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Barrys Lane 21085 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Transport 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter (nmn) __Moffett Marie Eileen Hamby 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurie Moffett /Wife 800 Barrys Lane, Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Byria/ 2 ☑ Cremation 3 □ R 4 □ Donation 5 □ Gittler (Specify) 21. Sign to e of Funer /3 rviv. LL3nv 3 ☐ Remøval from State Hillton Service Corp. 2-20-08 Towson, Maryland 22 Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Hart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final cardio pulmonary arrest disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐Unknown 23e. Did tobacco use contribute to the cause of death? ner significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown yngeal cancer 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA

permit. Pages 1 and 2 should be filed will Department of Health and Mintal Hygien. Important: if item 27 is marked other this any I jury or other traumatic event; the once Physician /Medical Examiner Examiner and

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be

Funeral

Director

ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

has

certificate be executed within 24 hours a

| sted by Physician/Medical | IF FEMAL 23b. Was in the 1 1 9 10 Part II. Oth |
|---------------------------|--|
| Completed by | lar |

29a. Certifier

Be

Certification: To

Medical

1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident

29b. Signature and title of certifier

5 Pending investigation 6 ☐ Could not be 3 ☐ Suicide

4 Thomicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0043909 February 15,2008

Averill Road Joppa, mp 21085 M.D 902 stephanie 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

FEB 2 0 2008

mance

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #30, perDVR, g876, 2/20/08 Tertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 02-12-2008 Joseph A. Nacci 1611 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Days Hours Director 213-26-9178 79 10-05-1928 Maryland Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10b. County 10d. Inside City Limits ¹⁰a State Penn– 1 ☐ Yes ŽX No Director sylvania York New Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 5 be "natural", or items 23a 1358 Fawn Grove Rd Funeral 17352 U.S.A.

14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Be Completed er than "natur, the Medical E and Mental Hygiene.
To sand marked other the er traumatic even* 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Claims Manager State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Salvatore Nacci Santina DiTullio ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any Injury or other tra Dolores Nacci (Wife) 1358 Fawn Grove Rd New Park, PA 17352 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 02-14-2008 | Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Home of Bel Air permit. 21. Signature of Funeral Service Licensee Buai a Well Inc. 610 W. MacPhail Rd Bel air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Hemorrhagic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Gastrointertinal hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed Due to (or as a consequence of) physician a Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No o∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Cardiomyopathy 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an 2 No 1∐ Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 0 filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. the 29c. License number 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) asin 063420 tebruary 12,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sid Z. Kharal, MD Upper CHesapeake Medical Center, Bel Air, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 2 0 2008 Registrar

DHMH 17 Rev 1/2001

9

Vacci

| | | | For State Registrar | State of M | laryland | | ertment o | | | nd Me | | iene? | 008 | 05043 |
|-----------|--|----------------|---|---|-----------------------|--------------------------------|----------------------------------|-------------------------------|------------------------|--------------------------|---|------------------------------|---------------------------------|---------------------------------|
| 1 | Physicia | an | 1. Decedent's Name (First, Middle, Las | st) | | | | - | | 1 | 2. Date of Deat Month | | Year | 3. Time of Death |
| | /Medic | | LOIS | | | | NELSON | | | | 'EBRUAR' | | 2008 | 5:00 A M |
|) | Examin | er | | lame (If not institution, give street and number) ST HILL HEALTH & REHAB CENTER | | | | | cation of | HILL | | 40.000 | inty of Death HARF(| ORD |
| | Funeral | | 5. Social Security Number 6. S | | | ast birthday) | If Under 1 Y | ear If | Under 2 | | | Vacal | 9. Birthp | lace (State or Foreign |
| | Director | | 219-14-0668 | □M 2∏ F | 82 | Yrs. | Months D | ays H | Hours | Min. | B. Date of Birth (Month, Day, ug 6, | 1925 | Mary] | |
| ٦ | pu , | | Usual Residence of Decedent | | 10c City | , Town or Lo | cation | | | | | | 1 | 0d. Inside City Limits |
| | laryla shov ed at | 'n | 10a. State 10b. County MD Harfore | d | | Bel Ai: | | | | | | | | 1 □ Yes 2√□ No |
| | the N 28a-f notifie | Directo | 10e. Street and Number | | |)CI 11I. | 10f. Zip Co | de | | | 1 | 0g. Citizen | of What Cour | |
| | h with | | 950 Redfield Road | d #D | | | | 21 | 1014 | | | | USA | |
| | ems Ser mu | Funeral | 11. Marital Status | 12. Was Deceden Armed Forces | ? | 3. 13. | Was Decedent | of Hispa Cuban, N | anic Origi Mexican, | in? (Speci Puerto Ri | ify Yes or No- ican, etc.) | | Race - Americ Black, White, | |
| 20 | filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at | by Fu | 1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates | No | | 1 □ Yes 2 🛭 | | | | | Spe | ecify: whi | .te |
| 5-0036 | hour tural | ed b | 15. Decedent's Ed | | | 16a. Deced | dent's Usual O | ccupatio | n | | - 1 | 16b. Kind o | of Business/Inc | dustry |
| | in 72 in "na Medic | Completed | (Specify only highest gra | de completed) College (1-4or | .5+) | (Give life. l | kind of work a DO NOT use r | one durir etired) | ng most | of working | " | | | |
| 7.7 | d with giene er tha the I | moC | | ınk | 01) | | baby | | | | | | dcare | |
| yland | be filed tal Hygi d other event, tl | Be | 17. Father's Name (First, Middle, Last, Wilmer Decatur Mo | | | | | | | , | First, Middle, i netine | | , | |
| <u> </u> | Men Jarke Jarke | ဥ | 19a. Informant's Name/Relationship (| | | 10h Mailis | an Address (Ci | | | | Route Numbe | | | (Cada) |
| Nar | nd 2 sh lith and 27 Is n r traun | | Forest Hill Heal | | b | | | | | | Fores | | | |
| ē, | ss 1 au of Hea item | | 20a. Method of Disposition | ID | i c | lace of Dispo emetery, crer | sition (Name o | of r place) | | Da | te | 20c. Locati | on - City or To | own, State |
| aitimore, | Page nent d ant: If ury or | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specif | | e | | | | | | | | | |
| Balt | permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 Is marked other tta any injury or other traumatic event, th <u>once.</u> | | 21. Signa sup of Funeral Service Licer | Wade, Din | ector | | Name and A ate An altimor | | | bard 21201 | 655 W. | Balti | Lmore S | Street |
| | | | 23a. Part1 Enter the disease, or com shock or heart failure. List only | plications that cause one cause on each | ed the death line. | | | | | cardiac or | respiratory arr | est, | | Approximate Interval Between |
| | Physician | Ì | Immediate Cause (Final disease or condition | a my | rear | in la | fu. | tron | | | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or a | s a consequ | ience of): | | | | | | | | |
| | ************************************** | Į. | Sequentially list conditions, if any, leading to immediate | b. Due to (or a | s a cons | ience of): | Ma_F | | | | | | | |
| | uted I Insit | Examiner | cause. Emer Underlying Cause (Disease or injury that initiated events | | | | | | | | | | | |
| o T | exection and and rial-tra | | resulting in death) Last | C Due to (or a | s a consequ | ence of): | | | | | | | | |
| 2/60 | death certificate be executed e attending physician and id for use as the burial-transit | dical | | _d | | | | | | | | | | |
| ٥ | ertifica ling pl | Med | IF FEMALE: | One If we autnom | o of progno | 201 | | | | | | | | |
| ROX | leath certific attending p I for use as 1 | ian/ | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant | 2 ∐ Fetal | Ideath 3L | ⊒Ectopic pregi ⊒ Other (speci | | | | | 23d. | Date of delive Month | ery Day Year |
| o. | at the de by the a tached | Physician/Med | 1 Yes 2 No 9 Unknown | 9□Unknown | at time or de | batti JL | | | | | | | | |
| 7 | requires that the een signed by th hould be detache | by Pr | Part II. Other significant conditions | contributing to death | but not resu | ulting in the u | nderlying caus | e given i | in Part I. | | 23e. Did to | bacco use | contribute to t | he cause of death? |
| ecords, | w requires that s been signed k should be deta | ed b | dialites | | | | | | | | 1 🗆 Y | es 2□N | lo 3□ Prol | bably 4 Unknown |
| ပ္ပ | S b | Completed | addison de | seng | | | | | | | 24a. Was a | in 2 | 4b. Were auto | opsy findings available of |
| ř = | The ate h page | Som | atual fel | ullatur | | | | | | | perfor 1 Yes | med? 2□No | death? 1 □ Yes | 2 100 |
| Vital H | Physician: The Is this certificate ha ral director, page 2 | Be | 25. Was case referred to medical examiner? | Hospital: | | | | L | | | (Check only o | | | |
| 0 | Phy this | 7. | 1 ☐ Yes 2 ☐ No 27. Manner of Death | 1 ☐ Inpa 28a. Date of Ir | | ER/Outpatier 28b. Time o | | | 4 Nur | - | e 5 ☐ Resid | | | fy) |
| | ding I. After fune | tion | 1 Natural 5 Pending 2 Accident investigation | (Month, E | Day Year) | Injury | м | Injury at Work? 1 ☐ Yes | s 2N | | 34. 50001.50 1. | on anjuny or | 5541154 | |
| DIVISION | Attending or death. rector: After by the funer | Certification: | 3 Suicide 6 Could not b 4 Homicide determined | e 28e. Place of i | njury - At ho | me, farm, sti | reet, factory, o | ffice | | 28 | Bf. Location (S City or Tow | treet and N | umber or Run | al Route Number, |
| 5 | tal or s afte al Dir | Certi | 4 Florillade | building, | etc. (Specify | <i>')</i> | | | | | City of Tow | n, olale) | | |
| | To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the | Medical (| 29a. Certifier Check only one) Certifying Pi | nysician: To the bes miner: On the basis and manner | of examina | wledge, deat tion and/or ir | h occurred at ovestigation, in | the time, my opin | date and | d place, a th occurre | nd due to the o | cause(s) and date and pla | d manner as s ace, and due t | stated. to the cause(s) |
| | To the within To the compl | Me | 29b. Signature and title of certifier | | | | 29c. L | icense n | umber | | | 29d. Date s | igned (Month, | Day, Year) |
|) | | | Daves | 0 | | | 9 | 53 | 22 | 15 | 1 | elru | m 11, | 200V |
| | | | 30. Name and address of person who | | | | | | | | | | 0 | |
| | | | | 515 W. MAC | | | - BE | L AI | IR, N | MD. | 21014 | | | |
| ľ | Sta Registi | | 31. Date filed (Month, Day, Year) 20 | 08 Hegis | strar's Signa | Rule | ME | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Dav **Physician** James Rona ${f ld}$ Newel ${f l}$ 02. 12:26P [™] 17.2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson <u> Gilchrist Hospice Center</u> If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1. M 2□F Director 219.38.0662 10.08.1942 KY Usual Residence of Deceden 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f show notified at show 1 □Yes 2 No Director MD Baltimore Dundalk 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or amy Injury or other traumatic event, the Medical Examiner must be nonce. 21222 U.S.A. 503 Brandyvale Way

1. Marital Status

12. Was Decedent Ever in U.S.

Armed Forces? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Folices:

1 Pres 2 No
If Yes, Give
Year or Dates 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) Factory Printer 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Blair James Ronald Newell, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 Brandyvale Way, Dundalk, MD 21222 Prisilla Newell/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State Chesapeake Crem. 02.20.07 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M01443 8717 Green Pastures Dr. BAlto., MD Approximate Interval Between Onset and Death 23a. Part1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a onsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the drawing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician and use as the burial-tran Due to (or as a consequence of) 68760 Physician/Medical use as the Box IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant atten for u 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Ö 9 Unknown ٦. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed2 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: ospital or Attending hours after death. 5 ☐ Pending investigation 1 Natural 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of pertifier 1)25205 5+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N-Charles St. Balto Md Zizik BMC 6701 Riley 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 1 tem 23c per doc 876 2-20-08 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Year LINDA DORAINE NORMAN 9, **FEBRUARY** 15:40 /Medical 2008 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 525 Richmond Street Perryville Cecil If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2X F 217-78-6205 Director Feb. 24, 1961 46 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Cecil Perryville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 525 Richmond St. 21903 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joanne Ruth Enders Frank Earl Jackson ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maynard Lee Norman / Husband 525 Richmond Street, Perryville, Maryland 21903 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State St. George's Episcopal 2-13-08 Perryman, Maryland 21. Signature of Funeral Service Licen McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 ation hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part1. Enter the disease, or com-shock, or heart failure. List only Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cirrhosis of the liver to ascitcs The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death Month Day Year 5 Other (specify) 1 ☐ Yes 2 ₩ No 9☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 22 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No P 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1-Natural injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0026183 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAchder, 322 (ecil M.D 31. Date filed (Month, Day, FEB 2 0 2008 Registrar

| | - | For State State Registrar | OI Maryiai | | irtment of H tificate of L | | , , | Reg. No. 2008 | 05046 |
|---|----------------|--|--------------------------------------|------------------------|---|--|----------------------------------|----------------------------|---|
| A Division | | Decedent's Name (First, Middle, Last) | | | | | Date of Dea Month | ath Day Year | 3. Time of Death |
| Physicia /Medica | | EMMA ELIZABETH NABB | | | | | | RY 17 2008 | 9:15 A ^M |
| Examine | er | 4a. Facility Name (If not institution, give street and | | A TET ON | | Location of Death | | 4c. County of De | ath |
| | | FOREST HILL HEALTH & N. 5. Social Security Number 6. Sex | 7. Age (In yrs. | | FOREST I | If Under 24 Hrs. | 8. Date of Birtl | HARFORD 9. Bi | rthplace (State or Foreign |
| Funeral Director | | 212-30-1274 Usual Residence of Decedent | | Yrs. | Months Days | Hours Min. | Sep. 22 | , 1917 M | rthplace (State or Foreign ountry) iaryland |
| /land ow at | ŀ | 10a. State 10b. County | 10c. Ci | ty, Town or Lo | cation | | | | 10d. Inside City Limits |
| Mar a-f sh iffed | io | Maryland Harford | | Fores | t Hill | | | | 1 ☐ Yes 2 ☐ No |
| or 28 | Directo | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of What C | ountry? |
| ath w | | 109 Forest Valley D | | | | 050 | | USA | Jan Indian |
| er de | Funeral | Armed | Pecedent Ever in U Forces? | J.S. 13. \ | Vas Decedent of Hi f Yes, specify Cuba | ispanic Origin? (Sp ın, Mexican, Puerto | ecify Yes or No- Rican, etc.) | 14. Race - Am Black, Wh | |
| rs aft xami | by | 1 Never Married 2 Married 1 Yes 3 Widowed 4 Divorced Year of | es 2 XNo Give or Dates: | | ☐ Yes 2 No | Specify: | | Specify: W | hite |
| ING 21215-0036 be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural"; or items 23a or 28a-f show event, the Medical Examiner must be notified at | ted | 15. Decedent's Education (Specify only highest grade complet | adl | 16a. Deced | lent's Usual Occup | ation | ring | 16b. Kind of Busines | s/Industry |
| thin 7 | Completed | | e (1-4or 5+) | | kind of work done o |) | arig | | |
| ed wi | | 11 | | F | Iomemaker | 40 Mathada Nasa | - (Final Ministr | Own Ho | me |
| and I be fil ed otl | å | 17. Father's Name (First, Middle, Last) Benjamin Franklin Ste | vens | | | | e Jane S | * | |
| Maryland 21215-0036 d 2 should be filed within 72 hours af tht and Mental Hygiene. 77 is marked other than "natural" or traumatic event, the Medical Exami | ၉ | 19a. Informant's Name/Relationship (Type. Print) | VCID | 19b. Mailin | a Address (Street a | | | er, City or Town, State | Zip Code) |
| Ma nd 2 s alth ar 27 is rtrau | | Harold Daniels Jr. / | Son | 343 | 3 Dublin | Road Da | arlingto | n, MD 2103 | Δ. |
| ore, lest and of Health fitem 27 | | 20a. Method of Disposition | 20b. | Place of Dispo | sition (Name of natory or other place | re) | Date | 20c. Location - City of | r Town, State |
| Pages Pages nent of int: If it | | 1 ☑ Burial 2 □ Cremation 3 □ Removal fr 4 □ Donation 5 □ Other (<i>Specify</i>) | | | of Faith | | 9-08 | Baltimore | , Maryland |
| Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other | | 21. Signature i Funeral Service Licensee | eds | | Name and Address ACCOMAS F | | | don, MD 21 | 000 |
| | 1 | 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause | t caused the dea | th. Do not ent | er the mode of dyin | g, such as cardiac | or respiratory ar | rest, | Approximate Interval Between |
| Physician | | Immediate Cause (Final disease or condition | 01 10 11. | low | 2 | | | | Onset and Death |
| /Medical Examiner | | resulting in death) Due | to (or as a conse | quence of): | noting | _ | , | | |
| State of the state of | _ | Sequentially list conditions, b | pher | resp | noting | mark | unfec | lion | |
| nsit red | nine | Cause (Disease or injury | TO (CA SA D CO TOB | quence on. | | | | | |
| 760, be executed sician and burial-transit | Examiner | triat illitiated events | to (or as a conse | quence of): | | | | | |
| | edical | d | | | | | | | |
| C 68 ertifica ing ph | Med | IF FEMALE: | | | | | | | |
| Geath certificate attending of for use as | Physician/M | 23b. Was decedent pregnant | outcome pf pregr ve birth 2 ☐ Fet | aldeath 3□ | Ectopic pregnancy | , | | 23d. Date of o | elivery Day Year |
| . 0 00 0 | ysic | 1 □ Vos 2 □ No | egnant at time of nknown | death 5L | Other (specify) | | | | • |
| The law requires that the tab has been signed by the lage 2 should be detached. | | Part II. Other significant conditions contributing | o death but not re | sulting in the u | nderlying cause give | en in Part I. | 23e. Did to | obacco use contribute | to the cause of death? |
| w requires that is been signed to should be deta | od by | | | | | | 1 🗆 1 | Yes 2□No 3□ | Probably 4 Unknown |
| s bee | Completed | | | | | | 24a. Was | an 24b. Were | autopsy findings available |
| | E O | | | | | | | rmed? death | |
| r Vital Records, ystdan: The law requires the list certificate has been signed director, page 2 should be d | Be | 25. Was case referred to medical examiner? | | | | 26. Place of Dear | | • | |
| Or V Physic | 0 | 1 ☐ Yes 2 No Hospital: | ☐ Inpatient 2 ☐ | 1 | | 4 Nursing H | | dence 6 Other (Si | pecify) |
| Invision or I or Attending Physafter death. Director: After this is in by the funeral of | .: 0 | 1 Natural 5 □ Pending | ate of Injury Month, Day Year) | 28b. Time of Injury | Wor | yat k? Yes 2 □ No | 28d. Describe I | now injury occurred | |
| ISIC vittenc death ctor; y the | cat | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e. P | ace of injury - At h | nome, farm, str | | res ZUNO | 28f. Location (S | Street and Number or | Rural Route Number, |
| DIVI | Certification: | 4 Homicide determined b | uilding, etc. (Spec | ify) | | | City or Tov | | |
| ospita hours unera ly fille | | 29a. Certifier (Check only) 1 Certifying Physician: To 2 Medical Examiner: On the | the best of my kn | owledge, death | occurred at the tir | me, date and place | , and due to the | cause(s) and manner | as stated. |
| DIVISION OF VITAI To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director. | edica | one) and t | nanner stated. | | | | | | |
| To Toon | Σ | 29b. Signature and title of certifier | | | 29c. Licens | | | 29d. Date signed (Mo | |
| n_{n} | | Frank 3Du | | 00c\ /T | | 32299 | | February | 18,2008 |
| '2 | | 30. Name and address of person who completed DR. DAVID DUNN - $615~\mathrm{W}$ | MACPHA] | L ROAD | | R, MD 21 | 014 | | |
| 1 | | | 2. Registrar's Sigr | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month OZ Day Year **Physician** 0155 A M 12 2008 Alethia A. Pickard /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Franklin Square
5. Social Security Number Baltimore 1 tospital Tosedale If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months Davs Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days 69 1 □ M 2 ⋤ F Yrs 08-12-1938 MD Director 215-34-9377 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygtene. Important: If item 27 is marked other than "naturat", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No Director Harford Joppa MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21085 2413 Gilwood Drive Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 XI If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 X No 平ickard, Alethia Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna V. Conley William Arnholter ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2413 Gilwood Drive Joppa, MD 21085 Alfren J. Pickard 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ □ Other (Specify) 02-15-2008 | Baltimore MD Moreland Memorial ature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. Nottingham, MD 21236 9705 Belair Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner Obstruction -olon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760. Fo the Hospital or Attending Physician: 24 hours after death.

within 24

State Registrar

Medical

4 Homicide

(Check only one)

29a. Certifier

Textifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title pertifier

29d. Date signed (Month, Day, Year) 29c. License number

02/12

2008

RES00000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. PRABHAKAR REDBY 4000 Baltimore, MD 21237

2. Registrar's Signature 31. Date filed (Month, Day, Year) 2 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Victoria C., Peeler February P^{M} 2008 /Medical :58 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Anne Arundel Medical Center Annapolis Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Y Sept. 16 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Vear 1 ☐ M 2 🖸 F 214-22-9648 Sept. 80 Director 1927 MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notifled at Director 1 ☐ Yes 2√ No Maryland Anne Arundel Pasadena 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 7695 Briar Lane 21122 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 ☑ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify. White Specify: 3 ☑ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Chief Custodian Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Rice ပ Victoria Unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7695 Briar Lane, Pasadena, MD 21122 John W. Peeler III (son) Date 21 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Feb 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 2008 4 Donation 5 Other (Specify) Glen Burnie, Maryland 22. Name and Address of Facility 21. Signature of Funeral Se Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 disease, or complications that collure. List only one cause on a 23a. Part . Enter th disease shoot, or heart filure. used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, th line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** o (or s a consequence of) /Medical Due to (or Examiner vinar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions obstributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 1 1 Tes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy perform certificate 1 ☐ Yes 2 ☐ No director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P npatient 2 ER/Outpatient 3□ DOA Date of Injury (Month, Day Year) 27 Manner of Death Certification: 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. Box 68760, the Hospital or Attending Physician: filled in by within 2

> State Registrar

Medical

29a. Certifier

30. Name and

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

duress of person who

FEB 2 0 2008

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FEBRUARY fermu tT ore tta 2008 РМ 5:22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sulgrave Avenue timore N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 09/15/1918 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 □ M 2 💢 F 89 Director 209-10-6213 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits "natural", or items 23a or 28a-f sh edical Examiner must be notified MD N/A BALTIMORE 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2303 SULGRAVE AVENUE 21209 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marîtal Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 🛣 No WHITE Specify ģ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If Item 27 is marked other the any injury or other traumatic event, the once. HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HARRY PAUL RACHEL DAVIS ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SOLBERT PERMUTT / HUSBAND 2303 SULGRAVE AVENUE, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🗖 Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP 02/20/2008 4 ☐ Donation TOWSON, MD 5 ☐ Other (Specify) 21. Signature of Juneral Service Lio SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part1. Enter the disease, or complications that shock, or heart fallure. List only one cause on Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ancreatic ancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and burial-tran Due to (or as a consequence of): attending physiclan for use as the buris Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ed by the a 1 Yes 2 No. 9 Unknown signed by d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an page 2 certificate 1□ Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 X Residence 6 □Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred After (Month, Day Year) 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident filled in by the 6 ☐ Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

requires that the death certificate be executed Box 68760, Division or Vital Records, P.O. or Attending Physician: death. after death within 24 hours a

within 72 hours after death

Baltimore, Maryland 21215-0036

10

completely

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

5505 31. Date filed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

and manner stated.

29c. License number D3576

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Hop Kins Bay View Circle

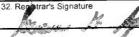
| | | | For State Registrar | State of Ma | | Department of F Certificate of I | | | jiene _{leg. No.} 2001 | 8 05050 |
|---------------------|---|----------------|---|--|------------------------------------|---|---|----------------------------------|-----------------------------------|--|
| 5 | Dhysis | | 1. Decedent's Name (First, Middle, | Last) | | | | 2. Date of Dear | | 3. Time of Death |
| 100 | Physici /Medi | | Oliver Doming | | | | | | ry 17, 200 | 08 6:30 P. ^M |
| | Examir | ier | 4a. Facility Name (If not institution, Manor Care-Woo | , | 11077 | 4b. City, Town, o | r Location of Death | | 4c. County of De | |
| | Funeral | | | | i (In yrs. last birt | thday) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Baltimo | Birthplace (State or Foreign |
| b | Director | | 215-12-1718 | 1⊠M 2□F | 89 | Yrs. Months Days | Hours Min. | (Month, Day, Jan. 9, | , Year) | Country) |
| | nud N | | Usual Residence of Decedent 10a, State 10b, County | | 10c. City, Town | a or Location | | | | |
| | Maryla f shored at | ō | | | | | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No |
| | the f | Director | MD Baltin | nore | Catons | 10f. Zip Code | | 1 | 0g. Citizen of What | |
| | th with | al D | 604 Olesmont 1 | Road | | 21228 | | | USA | |
| | r dea tems er mu | Funeral | 11. Marital Status | 12. Was Decedent E Armed Forces? | | 13. Was Decedent of H If Yes, specify Cuba | ispanic Origin? (Spean, Mexican, Puerto | ecify Yes or No- Rican, etc.) | | nerican Indian, |
| 36 | rs afte I', or i | by F | 1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced | 1 X Yes 2 ☐ N If Yes, Give Year or Dates: | lo | 1 ☑ Yes 2 ☐ No | Specify: Cuba | | Specific | |
| 9 | 2 hour | led k | 15. Decedent's | Education | 16a. | Decedent's Usual Occup | ation | | 16b. Kind of Busines | nite |
| 2 | be filed within 72 hours after death with the Maryland ntal Hyglene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Completed | (Specify only highest Elementary/Secondary (0-12) | grade completed) College (1-4or 5- | +) | (Give kind of work done life. DO NOT use retired | during most of worki i) | ng | | |
| 7 | ed wi | Con | 11 | | | Carpenter | - | | Housi | ng |
| Maryland 21215-0036 | d d d | Be | 17. Father's Name (First, Middle, La Leon Pilot | st) | | | 18. Mother's Name Mabel R | | Maiden Surname) | |
| Ž | should ind Men marke umatic | 은 | 19a. Informant's Name/Relationship | (Type, Print) | 19b. | Mailing Address (Street | | | r City or Town State | Zin Code) |
| | ges 1 and 2 should it of Health and Men If item 27 is marke or other traumatic | | Mary Pilot | Wife | | 4 Olesmont | | | | • |
| ore, | es 1 a of He of He fitem | | 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 | | 20b. Place of cemeter | Disposition (Name of y, crematory or other place | re) | | 20c. Location - City | |
| Ĕ | Pages ment of tant: If its jury or o | | 4 □ Donation 5 □ Other (Spe | | | ne Park | 2/22/ | | Woodlawn, | |
| Baltimore, | permit. Pages Department of Important: If it any injury or conce. | | 21. Signature of Funeral Service Li | enses | | 22. Name and Addres | ss of Facility Ster | rling As | shton Schw | ah Witzke |
| | 482 60 | Н | 23a Part 1 Enter the disease or or | 7 // Cleans | | 1630 Edmon | dean Aven | ue: Cato | nsville. | MD 21228 |
| | Dhuaisian | | 23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final | 4(| - | | | n respiratory arre | est, | Approximate Interval Between Onset and Death |
| | Physician Medical | | disease or condition resulting in death) | a | STATE | | CER | | | |
| | Examiner | | Conversation that are all to a | b | 1 | | | | | |
| 7 | d # | iner | Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exects) | Due to (or as a | consequence o | f): | | | | |
| V | ficate be executed physician and is the burial-transit | Examiner | that initiated events resulting in death) Last | c. Due to (or as | consequence o | ıt). | | | | |
| 28/60, | e be e sician buria | | | | | ,. | | | | |
| _ | requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit | ledical | | d | | | | | | |
| X Q Q | w requires that the death certific been signed by the attending p should be detached for use as | Physician/M | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome p 1⊡Live birth | | 3 □Ectopic pregnancy | | | 23d. Date of d | |
| | ne dea the at hed fo | sici | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4□Pregnant at 9□Unknown | | 5 ☐ Other (specify) | | | Month | Day Year |
| л О | that the ed by detacl | | Part II. Other significant conditions | s contributing to death bu | t not resulting in | the underlying cause give | en in Part I. | 23e. Did tob | pacco use contribute | to the cause of death? |
| S S | uires n sign | d by | HYPERTENSIVE | | | | | | | Probably 4 ☐Unknown |
| င္တ | law rec as beer 2 shou | Completed | | | | | | 24a. Was ai | n 24b, Were | autopsy findings available |
| Ĭ | The la | mo | | | | | | autops perforn 1□ Yes 2 | ned2 prior to death? | completion of cause of |
| vitai Kecords, | cian: ertifica ector, | Bec | 25. Was case referred to medical examiner? | | | | 26. Place of Death | | | 20110 |
| 0 | Physician: The law requ this certificate has been al director, page 2 should | ၉ | 1 ☐ Yes 2 ☑ No | | | patient 3 DOA Othe | 4 Will Nursing Hor | | ence 6 □Other (Sp | pecify) |
| | ding 1 h. After funer | ion | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat | 28a. Date of Injury (Month, Day | y 28b. Ti <i>Year)</i> In | jury Worf | / at ⟨? Yes 2 ∐ No | 28d. Describe ho | w injury occurred | |
| VISION | Atten | ficat | 3 Suicide 6 Could not | be 28e. Place of injur | ry - At home, far | m, street, factory, office | | 28f. Location (St. | reet and Number or i | Rural Route Number, |
| 5 | tal or s after al Dir ed in h | Certification: | 4 ☐ Homicide determine | building, etc. | . (Specify) | | | City or Town | n, State) | |
| | lospi 4 hour uner | | (Check only 2 Medical Ex | Physician: To the best o aminer: On the basis of | f my knowledge, examination and | death occurred at the tin | ne, date and place, a | and due to the ca | ause(s) and manner | as stated. |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | Medical | one) 29b. Signature and title of certifier | and manner stat | ted. | 29c. License | | | | |
| | F ≥ F 8 | | | · D | | | 59107 | | 9d. Date signed (Mod 0 2 - [9 | |
| 17 | 341 | - | 30. Name and address of person wh | | ath (Item 23a) (1 | | 21107 | | - 1 1 | -200 |
| _ | / | | | 210 BUSINS | | | REIST | ERSTOW | ~ Mo | 21136 |
| 5% | Sta | | 31. Date filed (Month, Day, Year) | 32. Registra | r's Signature | Car | - 1. | | | |
| | Registra | ar | FEB 2 0 2008 | All her A | The same | 10 m | | | | |

JEFF PayNe Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 28c per 1867 6 02/20/08dhb **UNK UNK** 1- For State Reg. No Registrar 2. Date of Death 3. Time of Deat 1. Decedent's Name (First, Middle,Last) Physician/ Month Day February 15, 2008 0115 hrs an Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) A NI **Baltimore** Good Samaritan Hospital 9. Birthplace State or Foreign 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Foreign Months Days -03-85 Country) 1 Director 22 218-45-9718 1 M Yrs Usual Residence of Decedent 10d Inside City Limits Town or Location 10b. County 10a, State 1 Yes 2 No irginia or 28a-f show A hours after death with the Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 205 14 Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Mantal Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Mamied 2 No Yes Specify: Hrican 1 Yes 2 No specify: 4 Divorced if Yes, Give Year Widowed Pages I and 2 should be filed within 72 hours after tent of Health and Mental Hygiene. \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) ommunications Installer Baltimore, MD 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Wilma Klimch arne essie Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) mother Piper Cresent Virginia Beach, VA 23454 1205 Wilma other trat 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State MD. Clarksville 2-23-08 portant: a 4 Donation 5 Other Specify: b 22. Name and Address of Excility Vaughn C. Greene Funeral Semies 5157 Baltimore Nat'l Pike Baltin 21. Signature of Funeral Service License elhe Baltimore, MA 21229 Approximate Interval the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enley Physician Between Onset and failure. List only one cause on each line. Death /Medical a. Gunshot Wound of Chest Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and cal AMENDED UNPENDED the attending physician ed for use as the burial Physician/Medi 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Year Month 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. signed by t I be detache o Yes 2 ✓ No 3 Probably 4 Unknown Completed by Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? 2 ✓ Yes 2 No 1 🗸 Yes page 26.Place of Death (Check only one) director, Hospital or Attending Physician: 25. Was case referred to medica Division of Vital Be examiner? Hospital: 1 Other Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient this 1 V Yes No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 1 28a. Date of Injury 27. Manner of Death Feb 15, 2008 Subject shot Certification: 0045 hrs Natural 1 Yes 2X No filled in by the fi Pending within 24 hours after death To the Funeral Director; Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) 1520 Pentridge Road, Apt. 108, Baltimore , MD Suicide determined (Specify) Multi-Family Apt. 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 15, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 32. Registrar's Signature 31. Date filed (Month, Bay Cear) 2008 State The state of Registrar **OCME**

DHMH 17 Rev 1/2001 **OCMF 2006**

State 31. Date filed (Month, Day, Year)
Registrar

Tasha Greenberg MD.



Assistant Medical Examiner

ORIGINAL

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last 2. Date of Death Stelman Raunell Day **Physician** arence 4c. County of Death February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NIA HOSPITAL BACTIMORE AGNES SAINT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 08 • 12 • 7. Age (In yrs, last birthday) (State or Foreign Social Security Number **Funeral** 251.10.2581 Months Days Hours 1**X**M 2□ F Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ns 23a or 28a-f show must be notified at Baltimore MD 1 XYes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5242 Fredcrest Road USA 21229 by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. and the man 27 is marked other than "natural", or Items 23, and 19 to other traumatic event, the Medical Examiner must ury or other traumatic event, the Medical Examiner must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rhodie 2 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frederist Road Balto. MD 21229 Ravnel 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: if ite any injury or ot 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 02 23 08 Baltmore, MD Arbutus Memorial 22. Name and Address of Facility \aughn C. Greene Funeral Son 1080 21. Signature of Funeral Service Licensee Baltimore National Pike Balto. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEUDOMONAS YNEW MONIA 3 DAYS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SuPression MMUNO if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner RANSPLANTATION OYEARS that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by FRILURE 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes EURAL EFFUSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2□ No 1 Tyes 24 hours after death.

e Funeral Director: After this certific letely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b Time of Medical Certification: 28a. Date of Injury 28c. Injury at Work? Division To the Hospital or Attending (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier within 24 hor To the Fune completely fi 2 dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO040012 FEBRUARY 16, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SCOTT POULTON, MD 405 FREDERICK ROAD, SOITE 204, CATOUSLILLE, MD 2128 SCOTT POULTON, MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

FEB 2 0 2008

LARENCE

RAUNEL

ORIGINAL

@32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗍 🗎 🥄 1 - For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 7:40 A. 14, 2008 February COLEMAN ROSSER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Westminster Dove House 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 6. Sex 5. Social Security Number Min. **Funeral** Days Hours Months 1 M 2 X Maryland Yrs. Mar. 26, 1915 Director 215-03-9359 Usual Residence of Decedent 10d, Inside City Limits death with the Maryland 10b. County 10c, City, Town or Location or 28a-f show The Medical Examinar must be notified at 1 Yes 2 □ No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. or Items 23e 2 Wyndhurst Avenue Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. Int: If item 27 le marked other then "naturel", or Iter 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify. Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 3 XWidowed 4 □ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 2 years of Health and Mental Hygie fitem 27 te marked other r other traumatic event. 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Charles Coleman Christine Dollinger 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 21204 Christie R. Mosely (daughter) 1503 LaBelle Avenue Ruxton, Maryland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2-16-08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 21212 6500 York Road Baltimore, Maryland Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit requires that the death certificate be executed that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?

1 Yes 2 No
9 Unknown ρ 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes 26. Place of Death Check onl one 25. Was case referred to medical examiner? Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death After Hospital or Attending 24 hours after death. 1. Natural 5 Pending 1 🗌 Yes 2 🗆 No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a 1 Critiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier within 2 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) onn (- Appelmo 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Alberta A Richardson State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle,Last) 2 Date of Death 3 Time of Death Physician/ Month Day February 14, 2008 0750 hrs Medical Examiner <u>Alberta A. Richardson</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 740 Poplar Grove Apt S2 Baltimore 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Foreign Months Davs Hours Director Country Virginia 2 X F 1910 231-14-4660 97 Sept 29, Usual Residence of Decedent any 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No 28a-f show MD Baltimore permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: for items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 740 Poplar Grave Street #S2 21216 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 2 X Yes 3 X Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: Specify: black ≥ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry unk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Corbin Malachi Blake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Frazier/daughter Coldspring Lane Baltimore, MD 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a, Method of Disposition Baltimore, 1 X Burial 2 Cremation 3 crematory or other place) Oaklawn Cemetery 2/26/2008 Donation 5 X Other Specify Baltimore, MD 22. Name and Address of Facility Varietin Greene Princial Services State Anatomy Board 639 W. Bullimore Street 21. Signature of Funeral Service Licensee, Ronald S, Wade, Director 4905 York Road MD 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical a. Atherosclerotic Cardiovascular Disease Death Immediate Cause (Final disease ⊂xamine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Physician/Medical UNPENDED X AMENDED . ,22,perFH,g876, 2/25/08 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 V No 9 Unknown Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> Yes 2 No 3 Probably 4 ✔ Unknown Completed ficate has been si page 2 should b 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has performed? death? Yes 2 ✔ No the funeral director, 25. Was case referred to medical 26.Place of Death (Check only one) Be Other4 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 After this 1 🗸 Yes ٩ 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Yaar) 28b. Time of Injury 28c. Injury at Work? 1 V Natural Yes 2 No Pending To the Funeral Director: completely filled in by the 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 24 cal 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. February 15, 2008 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D.

DHMH 17 Rev 1/2001 OCME 2006

Registrar

31. Date filed (Month, Day, Year)

FEB

ORIGINAL

32. Registrar's Signature

OCME

Fredo Ramone Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UNK UNK Certificate of Death 1- For State Reg. No 3' Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0950 hrs Month January 20, 2008 **Medical Examiner** Alfredo Ramone 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Hyattsville 1304 Merrimac Drive Date of Birth(MM/DD/YYYY)Birthplace (State or If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number unk 6. Sex Funeral | Months Days Hours Country' Director 29 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No Hyattsville Prince George's 23a or 28a-f show notified at once. MD 10g. Citizen of What Country' Director 10f. Zip Code 10e. Street and Number 1304 Merrimac Drive 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status unk If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married Yes Specify: 1X Yes 2 No specify: mexican white If Yes, Give Yea Divorced 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry ٥ unk 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 l permit. Pages I and 2 should be lited within 121 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical injury or other traumatic event. 15-0036 unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk unk 17. Father's Name (First, Middle, Last) Be 2121 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) lll Penn Street Baltimore, MD 21201 Q M O.C.M.E. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) Cremation 3 Removal from State Burial 2 Donation 5 X Other Specify: in 22. Name and Address of Facility 21. Signature of Euneral Service Licensee Ronald S. Wa State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Baltimore, lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part I. Enter the disease, or comp Between Onset and Physician failuce. List only one cause on each line Death Isopropanol intoxication complicated by hypothermia /Medical Immediate Cause (Final disease ıminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and The law requires that the death certificate be executed Physician/Medical #23a.27 ling physician a X UNPENDED perME.g876. .28a-f 23d. Date of delivery 23c. If yes, outcome of pregnancy Box 68760 IF FEMALE: Year Day Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown signed by the atte Unknown 9 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions o No 3 Probably 4 V Unknown Yes 2 ð 24b. Were autopsy findings available Completed 24a, Was an Division of Vital Records, prior to completion of cause of this certificate has been autopsy death? performed? 1 🗸 Yes ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: 24 hours after death. Other; Be Residence 6 V Other: Scene Nursing Home 5 Hospital: examiner? ER/Outpatient 3 Inpatient 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury subject exposed to low environmental 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death <u>ö</u> Yes 2 X No Natural Fnd 1/21/2008 Fnd 9:38 am 5 Pending temperatures Funeral Director: tely filled in by the 28f. Location (Street and Number or Rural Route Number, City Investigation 2 X Accident Certificat 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be 3 Suicide 1304 Merrimac Dr. Hyattsville, MD determined found in crawl space Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 V Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) To the I within 2 To the I and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

State Registra

OCME

0

rassel 30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

29b. Signature and title of certifier

Melissa Brassell, MD

31. Date filed (Month, Day, Year)

ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

January 22, 2008

| | | | For State Registrar | State of | Maryland / Dep | artment of H | | | giene Reg. No.200 | 8 05057 |
|---------------------|--|-----------------|--|--|--|---|--------------------|---------------------------------|---------------------------------|--|
| | 40.11 | | Decedent's Name (First, Middle, | Last) | | | | 2. Date of De | | 3. Time of Death |
| | Physici | | Eleanor Graha | m Coolow i | Pohhina | | | Month | | Year 08 4:30 P M |
| Yes | /Medic Examir | | 4a. Facility Name (If not institution, | | | 4b. City, Town, or | Location of Deal | _Februar | y 16 200 4c. County of | |
| | Examili | E | Laurel Regional | | ŕ | | | | | |
| | Funeral | | | | ⊥ 7. Age (In yrs. last birthday | | If Under 24 Hrs | | th | George's Birthplace (State or Foreign |
| | Director | | 219-48-1947 | 1 □ M 2 🔀 F | 91 Yrs. | Months Days | Hours Min. | . (Month, Da May 6, | y, rear) | Country) ashington, D.C. |
| | | | Usual Residence of Decedent | | <u> </u> | | | ray or | 1910 MS | ishing con, D.C. |
| | yland Jow | | 10a. State 10b. County | | 10c. City, Town or L | ocation | | | | 10d. Inside City Limits |
| | Mar a-fsl | ţ | MD Prince | George's | Laure | 1 | | | | 1 ☐ Yes 2 ☑ No |
| | hours after death with the Maryland tural", or items 23a or 28a-f show at Examiner must be notified at | Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of Wh | at Country? |
| | h wit | | 7902 Brooklyn I | Bridge Ro | he. | 20707 | 7 | | USA | |
| | ms | Funeral | 11. Marital Status | 12. Was Dece | | Was Decedent of Hi If Yes, specify Cuba | | Specify Yes or No | - 14. Race - | American Indian, |
| မွ | after or ite | | 1 Never Married 2000 Marrie | Armed For d 1 ☐ Yes | 2 ☆ No | | | nto Rican, etc.) | Black, | White, etc. |
| 8 | ral", c | þ | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Da | | 1 ☐ Yes 21X No | Specify: | | Specify: | White |
| 2 | 72 hc natu dical | Completed | 15. Decedent's (Specify only highest | Education | 16a. Dec | edent's Usual Occup | ation | urkina | 16b. Kind of Busi | ness/Industry |
| 21 | within ene. than "I | 혈 | Elementary/Secondary (0-12) | College (1- | 4or 5+) | e kind of work done o DO NOT use retired |)) | ining | | |
| 21 | gien gien er th | 등 | 12th | 5+ | Lib | rarian | | | Universi | ty Library |
| pu | be filed within 72 hours after dea ital Hygiene. Ind other than "natural", or items event, <u>the Medical Examiner</u> m | Be (| 17. Father's Name (First, Middle, L. | ast) | | | 18. Mother's Na | me (First, Middle, | Maiden Surname) | |
| /a | arkec | 2 | Jacquelin Smit | h Cooley | | | Nelli | e Leah G | raham | |
| Maryland 21215-0036 | s 1 and 2 should be if Health and Mental item 27 is marked other traumatic ev | | 19a. Informant's Name/Relationshi | p (Type. Print) | 19b. Mail | ing Address (Street a | and Number or R | ural Route Numb | er, City or Town, St | ate, Zip Code) |
| | T 2 E E | | Chandler S. Rob | bins/Husk | pand 7902 | 2 Brooklyn | Bridge | Road, L | aurel, MD | 20707 |
| re | ss 1 al | | 20a. Method of Disposition | | 20b. Place of Disp | | 1 | Date | 20c. Location - Ci | |
| Ĕ | Page nent o nt: If | | 1 ☐ Burial 2XX remation 3 4 ☐ Donation 5 ☐ Other (Spe | | itate | indel Crem | · i | 9/2008 | Odenton, | MD |
| Baltimore, | permit. Pages Department of Inportant: If Ite any injury or of | Ì | 21. Signature of Funeral Service Li | censee | | | 1 / | , | | Home, P.A. |
| m | permi Depa Impo any ir once | | AMIDO! | Alperd | | 313 Talbot | | | | 707 |
| 20 | 3 550 | | 23a. Part1. Env r the disease, or c shock o heart failure. List o | omplications that ca | | _ | | | | Approximate Interval Between |
| | Dhusisian | | shock of heart failure. List o | | | | | | | Interval Between Onset and Death |
| 17 | Physician /Medical | | disease or condition resulting in death) | a, | oiration Pneu | ımonia | | | | |
| | Examiner | | | | or as a consequence of): | 7 | | | | |
| 52 | | <u>-</u> | Sequentially list conditions, | U. | ite Renal Fai | lure | | | | |
| / | ted nsit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | | | nfoation | | | | |
| ۷ . | xecu and al-tra | xar | that initiated events resulting in death) Last | | nary Tract] | nrection | | | | |
| 8760, | death certificate be executed e attending physician and d for use as the burial-transit | a | | | hagia S/I | Pea Pu | be Place | eman+ | | |
| 387 | icate phys | dical | <u> </u> | d | magia b/i | 109 10 | De Flace | - IIICIIC | | - |
| 9 X | res that the death certific igned by the attending p be detached for use as | by Physician/Me | IF FEMALE: | 23c. If yes outo | ome pf pregnancy | | | | | |
| Вох | atten for u | ian | 23b. Was decedent pregnant in the past 12 months? | 1 ☐Live bi | rth 2 ☐ Fetal death 3 | ☐Ectopic pregnancy ☐ Other (specify) | | | 23d. Date of Month | |
| o. | he d the | ysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9□Unkno | | | | | | |
| P.0 | requires that the een signed by th nould be detache | P. | Part il. Other significant condition | s contributing to dea | ath but not resulting in the i | inderlying cause give | en in Part I | 23e Did to | obacco use contrib | ute to the cause of death? |
| 5 | signe signe | by | | g | g | g | | | | ☐ Probably 4万Unknown |
| Ö | | ec | | | | | | - | | |
| Records, | G & C/ | Completed | | | | | | 24a. Was autor | osy prid | ere autopsy findings available or to completion of cause of |
| - | The page | 2 | | | | | | perfo 1 Yes | rmed? dea 2.XNo 1.□ | ath?]Yes 2 X]No |
| Vital | Physician: The law r this certificate has b raf director, page 2 s | Be | 25. Was case referred to medical examiner? | | | | | ath (Check only o | ne) | |
| - | Physi this o | ဥ | 1 ☐ Yes 2 ☐XNo | | patient 2 ER/Outpatie | | 4 LI Nursing F | Home 5□ Resid | dence 6 □Other | (Specify) |
| Division or | ding P .r After t funera | Certification: | 27. Manner of Death 12 Natural 5 ☐ Pending | 28a. Date of (Month) | f Injury 28b. Time on 28b. Time of 28b. Time | Work | | 28d. Describe I | now injury occurred | |
| <u>S</u> . | endi eath. or: A | äţį | 2 ☐ Accident investiga | | | M 1 0 | Yes 2 ☐ No | | | |
| ≅ | i or Attend after death. Director: / | Ĭ | 3 Suicide 6 Could no 4 Homicide determin | ed Zoe. Place | of injury - At home, farm, st g, etc. <i>(Specify)</i> | reet, factory, office | | 28f. Location (5 City or Tox | Street and Number vn, State) | or Rural Route Number, |
| | To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page | Ce | | | | | | | | 1 |
| | To the Hospitai within 24 hours a To the Funeral I completely filled | edical | 29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Medical E | Physician: To the to caminer: On the base | oest of my knowledge, dea sis of examination and/or i | th occurred at the time | ne, date and place | e, and due to the | cause(s) and mann | er as stated. |
| | the F lin 24 the F | edi | One) | and manne | er stated. | , , , , , , | | and at the time, | adic and place, an | a due to the dadde(3) |
| | To Too | Ž | 29b. Signature and title of certifier | ^ | 10 | 29c. License | number | | 29d. Date signed (| Month, Day, Year) |
| | | | Mydriety | 10 | 10 | D006 | 4760 | | Februar | y 19, 2008 |
| | 20 | ľ | 30. Name and address of person w | no completed cause | of death (Item 23a) (Type | Print) | | | | , |
| | 30 | | Mythily Vancha, | 730 | Van Dusen R | ad Laur | el, MD | 20707 | | |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32. | gistrar's Signatu | Marie J | | | | |
| | Registr | ar | FEB 2 0 | 2008 | The state of the s | - | | | | |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FEBRUARY 16, 2008 6:45 P M GLENN THOMAS ROBERSON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 110 Seevue Court Apt. A Bel Air Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**X** M 2 □ F 84 Director 238-28-2684 June 26, 1923 North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at ty∑Yes 2 No Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be a 110 Seevue Ct. Apt. A 21014 USA death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government 11 Quality Inspector Ith and Mental Hv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Thomas Roberson Mary (nmn) Wilson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health ar
Important: If Item 27 is 1
any injury or 110 Seevue Ct. Apt. A, Bel Air, MD 21014 Date 20c Location - City or Town Carol E. Roberson / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Bel Air Memorial Gdn 2-21-08 Bel Air, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 23a. Part I. En er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 50 W. Broadway, Bel Air, Maryland 21014 Immediate Cause (Final disease or condition resulting in death) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed and Due to (or as a consequence of) physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. RENAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed VASCULAR 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No HYPERTEVSION 1□ Yes 2☑No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident al or Attend after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 25027 MD 2008 FEBRUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BHYANKAR BEL AR NORTH AVE 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 10:37 PM Sample Feb 2008 Isiah 15 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death N/A Baltimore University of Maryland Medical Center 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 227.34.292 Months Days Hours Min. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Severn Anne Arundel MD 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Bastille Place USA 7893 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc.

African 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 ☐ Divorced Year or Dates: American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) State of Maryland eteran's 12th arade Ultreact 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Seven Sample Kosa Mae 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Oceanside CA 92058 Ridge Way Broderick Sample Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑Burial 2 □ Cremation 3 □ Removal from State Owings Mills, MD 25 08 Garrison Forest 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility \ aug In C. Greene Fineral senices Baltimore National Pike Balto MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Cerebroyascular accident days Sequentially list conditions, if any, leading to himselfact cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □ Ectopic pregnancy Month Year Day

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ral", or items 23a or 28a-f show Examiner must be notified at

"natural",

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other trainment.

the Medical

72 hours after death with

Baltimore, Maryland 21215-0036

Director

Funeral

<u>S</u>

Completed

Be

certificate be executed burial-transit

and

physician

signed by the d

certificate has , page 2

within 24 hours and control to the Funeral Director: Aff

the

Box 68760,

P.O.

Records,

Division or Vital

Physiclan; : After this certification funeral director, I

or Attending

Examiner Physician/Medical attending p

þ

Completed

Be

ို

Certification:

Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

4□Pregnant at time of death 9 Unknown

5 ☐ Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

right

lower

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown

24a. Was an autopsy performed? 1□ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No

25. Was case referred to medical 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 Natural

2 Accident

(Check only

29a, Certifier

5 Pending investigation

1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

Injury 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) Feb 16 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Street, Baltimon, MD 21201 Mathad Greene

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MD

State Registrar

| ıysic | an | 1. Decedent's Name (First, Middle, L | George | & Smit | h Jr. | Mo | | ay 2002 | 3. Time of Death 2:15 A.M |
|---------------|----------------|--|---|-------------------------------------|---|--|------------------------------------|--------------------|--------------------------------------|
| Medi kamii | | 4a. Facility Name (If not institution, g | ive street and number) | , | 4b. City, Town, or I | | | c. County of Dea | 5 // / - |
| arran | iei | | VERTON ROA | D | | DAKK | | BALTO. | |
| al er | | 212-82-4198 | Sex 7. Age (In yrs. | last birthday) Yrs. | If Under 1 Year Months Days | Hours Min. 8. Da | te of Birth onth, Day, Yea. | 9. Bir | thplace (State or Foreign ountry) |
| | | Usual Residence of Decedent 10a. State 10b. County | 10c. Ci | ity, Town or Loca | ation | | | | 10d. Inside City Limits |
| | to | MD. BALTI | MORE | | | | | | 1 □Yes 2 🗹 No |
| | 1 Director | 1965 INUEI | STAN ROAD | | 10f. Zip Code 2/ | 222 | 10g. C | Citizen of What Co | |
| | Funeral | 11. Marital Status | 12. Was Decedent Ever in L Armed Forces? | J.S. 13. W | | panic Origin? (Specify Ye, Mexican, Puerto Rican, | es or No- | 14. Race - Am | encan Indian, |
| | þ | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | | | Yes 2 No | Specify: | etc.) | Specify: U | |
| | eted | 15. Decedent's (Specify only highest of | Education trade completed) | 16a. Decede | ent's Usual Occupat | on uring most of working | 16b. | Kind of Business | s/Industry |
| | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | _ | | iring most of working LONTRICTO 1 | 0 | PONTRA | CTOR |
| | | 17. Father's Name (First, Middle, La. | | 1 7 200 | | 18. Mother's Name (First, | | | |
| | To Be | GEORGE H. | SMITH SR. | | | PEGGY | A. G. | ERWIG | |
| | - | 19a. Informant's Name/Relationship | | 19b. Mailing | Address (Street ar | nd Number or Rural Rout | e Number, City | or Town, State, | Zip Code) |
| | | GINNY L. | DMITH | 196 | | VERTON RD | . DUN | DALK 1 | no. 21222 |
| | | 20a. Method of Disposition 1 December 2 ☐ Cremation 3 | | Place of Disposi cometery, crema | atory or ather place | h h /2 . | | Location - City or | Town, State |
| | | 4 Donation 5 Other (Spec | | AKLAWA | CEME | | 8 6 | PATO. | 2179 |
| | | 21. Signature of Funeral Service Lic | elisee () |) | Name and Address | FUNERAL HO | me 18 | 29 Hin | Service St. |
| | | 23a. I rt1. Enter the disease, or | implications that caused the | th. Do not enter | the mode of dying | | | A TIUL | Approximate |
| | | shock, or heart failure. List on Immediate Cause (Final | ly one cause on each line. | 1. 1 | | 1 | | | Interval Between Onset and Death |
| ľ | H | disease or condition resulting in death) | a. Due to (or as a conse | quence of): | Intar | CT ion | | | |
| ı | | Secuentially list conditions | b Corona | | rtery | disease | | | |
| | iner | Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conse | quen == of): | | | | | |
| | Examin | that initiated events resulting in death) Last | c. Due to (or as a conse | quence of): | | | | | |
| | calE | | d | | | | | | |
| | | | V. | | | | | | |
| | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pregn 1☐Live birth 2☐Fet | | Ectopic pregnancy | | | 23d. Date of de | |
| | SIC | in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 4☐Pregnant at time of 9☐Unknown | | Other (specify) | | | Month | Day Year |
| | Phy | Part II. Other significant conditions | contributing to death but not re | sulting in the unc | derlying cause give | n in Part I | Be Did tobacco | n use contribute | to the cause of death? |
| | d by | Circhocic | John Salang to doubt out not to | Sularing in the unit | Jonying Cause give | THIT GITT. | N 1 | | Probably 4 Unknown |
| | lete | Hantita | ^ | | | 20 | ta. Was an | 24h Were a | utopsy findings available |
| | Completed | - Hera ITIS | | | | | autopsy performed2 | prior to death? | completion of cause of |
| | 0 | 25. Was case referred to medical | 200 | | 71 | 26. Place of Death Che | Yes 2 | Yo 1 ☐ Ye | s 2 200 |
| | To B | examiner? 1 □ Yes 2 No | Hospital: 1 Inpatient 2 | ☐ ER/Outpatient | 3 DOA Othe | | | 6 ☐Other (Sp. | ecify) |
| | | 27. Manner of Death 1 Natural 5 Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury Work | | escribe how in | | |
| | cati | 2 Accident investigat 3 Suicide 6 Could not | ion he | | M 1 🗆 Y | es 2 No | | | |
| | Certification; | 4 Homicide determine | | nome, farm, stree ify) | et, factory, office | | cation (Street ty or Town, Sta | | Rural Route Number, |
| | ledical Ce | (Check only /2 Medical Ex | Physician: To the best of my kn aminer: On the basis of examin | lowledge death | oncurred at the first estigation, in my op | data and plans, and du inion, death occurred at t | ia to the cause he time, date a | (s) and Lanner t | in Mal 3.d. ue to the cause(s) |
| | D | one) | and manner stated. | | 29c. License | | | Date signed (Mor | |
| | Ne Ne | 20h Sinnatura and title of newfiles | | | ESC. LICETISE | | 29u. L | and signed (MO) | , 201, (001) |
| | Me | 29b. Signature and title of certifier | 1 | | D4191 | 0 | - | bruary | 7 2000 |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month 2 Year **Physician** 13 2008 1:03 PM mitt /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Regional PO Hospital aure If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1**№**M 2□ F Days 217-30-8903 10 25 1930 **Director** Maryland Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 wes 2 No Director Ellicott Howard 10g. Citizen of What Country? 10e. Street and Number o e items 23a (21043 by Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. "natural", or iten 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government 12 upervisor Department of Health and Mental Hyg mportant: If Item 27 is marked other any injury or other traumatic event, i Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 18. Be mith ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3mith 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 ☐Removal from State Marriottsville, restlawn 20/2008 Lemeter 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 10220 35WOM Approximate Interval Between Onset and Death of the disease, or complications that caused the death leart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, e Cause (Final ondition 1mmedia Aspiration Due (or as a consequence 2 Days **Physician** /Medical (or as a consequence of): Coronary Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Weeks physician and the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician 2 Weeks Physician/Medical as attending I IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? ned by the and detached for 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Johnnown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Ho favicinsons 11 Sease 24a. Was an has autopsy perform Dementia Yes 2 No Within 24 hours aller organ...

To the Funeral Director. After this certing the funeral director, in the funeral director r Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA ٩ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTENDING PHYSICIA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

37

DHMH 17 Rev 1/2001

State Registrar

Michael Batate 31. Date filed (Month, Day, Year)

Baako M.D. (32 negistrar's Signature

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7300 Van Dusen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 17,22,25 per fh/me 876,02/29/08dhb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Simons EARUARYIZ Dale Vanessa 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ST. AGNES HOSPITAL N/AALTIMORE r1 Year | If Under 24 Hrs 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 ■ M 2 3 F 214-56-5041 Yrs Director May 26,1952 Maryland 55 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f shov Baltimore N/A Maryland must be notified 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or USA 21215 4238 Roland View Avenue Funeral or Items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itel may Injury or other traumatic event, the Medical Exami 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) St. Agnes Hospital Elementary/Secondary (0-12) College (1-4or 5+) Film Library Supervisor 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sarah Guyton Henry ZSi Simons 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4238 Roland View Ave Baltimore, Maryland Sarah V. Simons / Mother 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 □ Removal from State Woodlawn, Maryland King Memorial Park 2/18/08 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Chap Chatman Harris Funeral

5240 Boistorstown Road Baltimore, Md Home 21. Signature of Puneral Service Licens 5240 Reisterstown Road Baltimore, 21215 23a. Part . Enter the diseas shock, or heart failure. ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, are. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** week /Medical Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): nding physician P.O. Box 68760 requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 ☑ Yes 2 ☐ No enerale this certificate or Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🖸 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident after death filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funeral 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier & Elickon, In.)

State Registrar

DHMH 17 Rev 1/2001

ムスス

WILLIAMJ

31. Date filed (Month, Day,

ST ACNES HOSPITAL BALTIMORE, MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HICKEN

M.D.

32. Registrar's gnatur

FEBRUARY 14, 2008 12:05 p.m.

DORIS SUMAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| th | | | | 3 Ti | me (| of De | ath | |
|-----------|---|---|---|------|------|-------|-----|---|
| eg. No. 🦳 | U | U | 0 | U | J | U | O | 0 |
| liene o | n | a | 0 | 0 | - | 0 | 0 | 1 |

| | | | - Registrar | | | | | Ce | rtitica | ite of i | Death | 7 | | R | eg. No. 🤇 | _ U | UU | U | 0000 |
|------------|--|-------------------------|---|-------------------------------------|----------------------------------|-----------------------------|-----------------------------|----------------------------------|---------------------|--------------------|------------|-------------------------|------------------------|-----------|---------------|-----------------|------------------------|-------------------|------------------------|
| | | -1 | 1. Decedent's Nan | ne (First, Middl | e, Last) | | | | | | | | | of Dea | | | V | 3. Tin | ne of Death |
| | Physici | | Doris (| Suma | n | | | | | | | | ${f Feb}^{	ext{	Mon}}$ | 14. | 200 | | Year | 12 | :05 p ^M |
| | /Medi | | 4a. Facility Name | | | reet and num | nher) | | 4b. Cit | y, Town, o | r Location | | 100 | | - | | of Death | | . оз Р |
| | Examir | ier | | | , g | out and man | | | | | | | | | | | nore 1 | νm | |
| | | | Stella 5. Social Security | | 6. Sex | | 7 A=0 (In um | . last birthday | - | onium er 1 Year | | er 24 Hrs. | 9 Data | of Birth | | | | | nto or Foreign |
| 25 | Funeral Director | | 214-14- | -0889 | | M 21K]F | 88 - 88 | Yrs. | Month | | Hours | | (Mor | nth, Day, | Year) 1919 | , | Countr | y) M | ate or Foreign D |
| | pu , | | Usual Residence | | | | 100.0 | ity, Town or L | costion | | | | | | | | 140 | el Impie | le City Limits |
| | larylan show ed at | _ | 10a. State | 10b. County | | | | | | | | | | | | | 10 | | Yes 2 No |
| | Ma-f s | cto | MD | Balti | more | | | Parkvi | тте | | | | | | | | | ' ' | res ZXINO |
| | 1 28 1 28 | ire | 10e. Street and No | umber | | | | | 10f. 2 | čip Code | | | | 1 | 0g. Citiz | en of W | /hat Countr | y? | |
| | 3a o | = | 921/ 0 | vermont | - Pos | nd | | | 21 | 234 | | | | | USA | A | | | |
| | be filed within 72 hours after death with the Maryland that Hyglene. do other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at | Funeral Director | 11. Marital Status | vermon | | | dent Ever in | U.S. 13. | _ | | lispanic C | Origin? (Spe | ecify Yes | or No- | | | - America | n India | n, |
| | lten ner | Į, | | rried 2 Mar | | Armed For 1 ☐ Yes | rces? | | If Yes, s | ecify Cub | an, Mexic | origin? (Specan, Puerto | Rican, e | tc.) | | Black | k, White, e | tc. | |
| 36 | s aff | by F | | 4 Divorced | | If Yes, Giv Year or Da | e | | 1 ☐ Yes | 2₺ No | Specif | y: | | | | Specify: | Whit | - 0 | |
| 21215-0036 | ural Ex | D D | 3 50 111001100 | | | | 1103. | 10- D | | 10 | - 42 | | | - | 101-161- | 1 - (D | | | |
| r, | 72 "nat | Completed | (Spe | 15. Deceder ecify only highe | nt's Educa es <i>t grad</i> e | ation co <i>mpleted)</i> | | (Give | e kind of | vork done | during m | ost of worki | ing | | IOD. KIN | d of Bus | siness/Indu | JSTry | |
| 21 | within ene. than ' | ldu | Elementary/Sec | condary (0-12) | | College (1 | -4or 5+) | | | | | | | | | | _ | | |
| 7 | y the | Ö | 12 | | | | | Priv | ate S | Secre | | | | | Rail | | | | |
| b | al Hygi other vent, ti | Be (| 17. Father's Name | e (First, Middle, | Last) | | | | | | 18. Mot | her's Name | (First, I | Middle, i | Maiden S | <i>Surn</i> ame | e) | | |
| ā | should be filed and Mental Hygi marked other matic event, ti | ToE | Willia | m Hetto | chen | | | | | | Be: | rtha l | Weis | gert | er | | | | |
| Maryland | S S S | - | 19a. Informant's N | Name/Relations | ship (<i>Typ</i> e | e. Print) | | 19b. Mail | ing Addre | ss (Street | and Num | nber or Rum | al Route | Numbe | r, City or | Town, S | State, Zip (| Code) | |
| | D # C I | | Shar A | A. Hohme | es | | | 2535 | Mar | ston | Rd. | New | Wind | lsor | MD | 2177 | 76 | | |
| <u>9</u> | of Heal | | 20a. Method of Dis | sposition | | | 20b. | Place of Disp cemetery, cre | | | | | Date | | | | City or Tow | vn, Sta | te |
| 2 | age out o | | | Cremation | | moval from S | State | | | | 1 | 00 10 | | | n 1 | | 3.6 | T | |
| Ë | nit. Parartmen ortant: Injury | | | 5 Other (5 | | (| Pa | rkwood | | etery and Addre | | 02-18 | | | | | ore M | | |
| Baltimore, | permit. Pages ' Department of H Important: If ite any Injury or of | | 21. Signature of F | -uneral Service | Licensee | 1.00 | 2 | | | | | 50 | | | | | 1 Hom | e I | nc |
| | | | Neu | in u. | ب | <u>ie de</u> | en . | | | | | l_Nott | | | | 1236 | _ | Approx | imata |
| | | | 23a. Part1. Enter shock, or he | the disease, o eart failure. Lis | t only one | e cause on ea | aused the dea ach line. | ath. Do not er | iter the m | ode of dyli | ig, such a | as cardiac (| or respira | atory arr | est, | | | Approx Interva | l Between and Death |
| | Physician | | Immediate Cause disease or conditi | e (Final ion | 1000 | CONC | FCTTVF | HEART | RATI | IIRE | | | | | | | | Onset | and Death |
| $j \top$ | /Medical | | resulting in death | | a. | | or as a conse | | LAL | JUICE | | | | | | | | | |
| | Examiner | | | | | | | | | | | | | | | | | | |
| FOG | | <u>-</u> | Sequentially list c if any, leading to i cause. Enter Und | onditions, | b. | Due to (| or as a conse | equence of): | | | | | | | | | | | |
| .7 | sit sit | Ë | cause. Enter Und | derlying | < | , | | 4 | | | | | | | | | | | |
| V | certificate be executed iding physician and ise as the burial-transit | Examiner | Cause (Disease of that initiated even resulting in death) | its I aet | c. | | | | | | | | | | | | - | | |
| 68760, | an a | ũ | resulting in death) | Last | | Due to (| or as a conse | equence of): | | | | | | | | | | | |
| 1 | te be ysici | cal | | | d. | | | | | | | | | | | | | | |
| 9 | ifica g ph | edi | | | | | | | | | | | | | | | | | |
| X | nding use | \/Medical | IF FEMALE: 23b. Was decede | ent prognant | 23 | c. If yes, out | come pf preg | nancy | | | | | | | 2 | 3d. Dat | e of deliver | v | |
| m | eath atter | siciar | in the past 1 | 2 months? | | | irth 2□Fe ant at time of | | □Ectopic □ Other | pregnanc | У | | | | | Mor | | Day | Year |
| o. | the d | Sic | 1 ☐ Yes 2 9 ☐ Unknow | P <u>K</u> JNo m | | 9 Unkno | | dedii 5 | | (3)001197_ | | | | | | | | | |
| P.0 | requires that the death een signed by the atter nould be detached for t | Phys | | | land soot | de disconte de | oth had not re | aultine in the | undaduin | a course div | ion in Day | et 1 | 220 | Didto | bacco ur | no contr | ributo to the | 0.0200 | e of death? |
| | gne gne | by | Part II. Other sign | incant conditi | ions cont | nouting to de | aun but not re | esulang in the | undenyini | y cause yiv | ren in Fai | ıtı. | 236 | | | | | | |
| Records, | quin en si uld t | | | | | | | | | | | | | 1 🗆 Y | es 2 |] No | 3 Proba | ably | 4X Unknown |
| ္ပ | > 0 0 | Completed | | | | | | | | | | | 248 | a. Was a | an | 24b. V | Were autop | sy find | ings available |
| 36 | e la has je 2 | E G | | | | | | | | | | | | autop | sy | l p | prior to com death? | pletion | of cause of |
| = | | ပိ | | | | | | | | | | | 1 | | 2 € No | | l□Yes | 2 🗆 No |) |
| or Vital | Physician: The this certificate ral director, pag | Be | 25. Was case refe examiner? | erred to medica | - | | | | | | | ce of Deatl | h (Check | k only or | ne) | | | | |
| - | S == | 2 | | No No | Ho | ospital: 1 □ I | npatient 2[| ☐ ER/Outpatie | ent 3 🗌 | DOA Oth | ner: 4□। | Nursing Ho | me 5 | Resid | ence 6 | X Othe | er (Specify | HO | SPICE |
| | | 2 | 27. Manner of Dea | | | 28a. Date | of Injury th, Day Year) | 28b. Time Injury | of | 28c. Inju | ry at | | 28d. De: | scribe h | ow injury | occurr | red | | |
| 0 | th. The | iệ. | 1 X Natural 2 ☐ Accident | 5 ☐ Pendii invest | ng igation | (IIIO/III | n, bay reary | linjury | M | | Yes 2 | □No | | | | | | | |
| S | Attending r death. ector: After you the fune | fice | 3 ☐ Suicide | 6 ☐ Could | | 28e. Place | of injury - At | home, farm, s | treet, fact | ory, office | | | 28f. Loc | ation (S | treet and | 1 Numb | er or Rural | Route | Number, |
| Division | l or Attencafter death Director: | Certification: | 4 Homicide | deterr | mieu | | ng, etc. (Spec | | | | | | | | n, State) | | | | |
| _ | | | 000 0000 | 177 0 | ma Dt. | olon: T: " | book of | nouls de la | th c=c= | od et #1 * | mo d-1 | and elec- | and de | to the | | an -1 | | ote - | |
| | Hospital | Medical | 29a. Certifier (Check only | | | | | nowledge, dea nation and/or i | | | | | | | | | | | use(s) |
| | the Hi in 24 the Fi | edi | one) | | | | ner stated. | 4 127 | | | | | | | | | | | |
| | To the within 2 To the Complet | Σ | 29b. Signature ar | nd title of certific | er) | | | | 1 | 29c. Licens | e numbe | er | | 1 | 29d. Date | signed | d (Month, L | Day, Ye | ear) |

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIO MAHMOOD

31. Date filed (Month, Day, Year)

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

| 08-00566 | |
|--------------|--|
| Thomas Smith | |

| | - 1 | I- For State Registrar | | Certifica | ate of i | Death | | Re | g. No. | 308 | 0506 |
|---|--|--|--|--|---|--|---|--|--|--|---|
| Physicia | an/ | Decedent's Name (First, Middle,La | ast) | | | | | Date of Deat Month | Day Yea | - | me of Death 145 hrs |
| al Exami | | Thomas Smith | | | Lak | o. City, Town, or Lo | action of Dooth | January 20 | 0, 2008 4c. County of | | 140 1115 |
| | | 4a. Facility Name (if not institution, g 645 Oak Hill Avenue Apt | t. BN | | | Hagerstown | | | Washing | gton | |
| Funeral Director | | 5. Social Security Number unk 6. | Sex 7. A | ige (In yrs. last birt | thday) Yrs. | If Under 1 Year Months Days | Hours Mir | | 3, 1949 | 9. Birthplac Foreign Country) | e (State ounk |
| any | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town | or Locatio | on | | | | 10d. | Inside City Limits |
| ž . | | MD Washir | noton | 1 " | rstow | | | | | 1 [| Yes 2 X No |
| Maryland 28a-f show d at once. | ctor | 10e. Street and Number | nat Country? | | | | | | | | |
| Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygens. I the Health and Mental Hygens and "natural", or items 23a or 28a-f sho mit. If tiem 71 is marked other than "natural", or items 23a or 28a-f sho not of the traumatic event, the Medical Examiner must be notified at once. | I Director | 645 Oak Hill Av | | | | | 1740 | Van an Na | US | A - American Ir | odios Black |
| ath wi tems st be | Funeral | 11. Marital Status 1 Never Married 2 Marrie | | s? unk | | Decedent of Hispa s, specify Cuban, I | | | | e, etc. | Idiati, black, |
| ter de | | 3 Widowed 4 Divorc | 1 Yes ed If Yes, Give Year | 2 No | 1 | Yes 2 X No | specify: | | Specify: | whit | e |
| ours af itural amin | g p | 15. Decedent's Education (Specify | only highest grade c | ompleted) 16a. | Decedent' | 's Usual Occupatio | n (Give kind of | work domank | 16b. Kind of Bu | usiness/Indust | ry unk |
| 72 ho n "na al Ex | Completed | Elementary/Secondary (0-12) | College (1-4 c | or 5+) | during mo | st of working life. D | O NOT use re | urea) | | | |
| led within 72 Hygiene. other than ' the Medical | ш | 01110 | unk | | | | | | | | |
| permit. Pages I and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical injury or other traumatic event, the Medical | | 17. Father's Name (First, Middle, La | ist) | | | unk 18 | .Mother's Nam | e (First, Middle, I | Maiden Surname | 9) | unk |
| ages I and 2 should be fil nt of Health and Mental E it: If item 27 is marked other traumatic event, | Be | 19a. Informant's Name/Relationship | (Type Print) | 10 | h Mailinn | Address (Street | and Number or | Rural Route Nur | nber. City or Toy | vn. State. Zip | Code) |
| shoul and N 7 is m | ဥ | | (Type, Fillit) | 1 | | enn Stre | | | | _ | 5545/ |
| and 2 ealth tem 2 traun | | O.C.M.E. 20a. Method of Disposition | | | | tion (Name of ceme | | Date | 20c. Location | | n, State |
| ges l t of H : If ii | | 1 Burial 2 Cremation | 3 Removal from | State | itory or oth | er place) | | | | | |
| it. Pa rtmen r tant y or c | 1 | 4 Donation 5 X Other Spec | ify: 1th state | e | 22 N | ame and Address f | f.Eaci lit y | 1 6EE 17 | Poltim | oro Ct | root |
| permit. Departm Imports injury o | | 21. Sinn the of unital envice-Lic | Di Di | rector | Sta | te Anatoi | ny-soar no 212 | מ ככס ש 10 א ככס | Dallin | ore st | Teet |
| ysician | - | 23a. Part I. Enter the disease, or contillure. List only one cause on | mplications that cause | ed the death. Do n | not enter th | e mode of dying, s | uch as cardiac | or respiratory arr | est, shock, or he | eart Ap | proximate Interva |
| de dical | ō | failure. List only one cause on | each line. | | | | | | | | |
| | 11 23 | Immediate Cause (Final disease | a Alcohol ar | nd methadon | e into | oxication | | | | 1 | Death |
| caminer | 0 8 | Immediate Cause (Final disease or condition resulting in death) | a. Alcohol ar | nd methadon | e into | oxication | | | | | |
| caminer | | or condition resulting in death) Sequentially list conditions, | Due to (or as a corb. | nd methadon | ne into | oxication | | | | | |
| aminer | | or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. | a. Alcohol ar | nd methadon | ne into | oxication | | | | | |
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| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transit | Certification: To Be Completed by Physician/Medical Examiner | or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last VINPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknoth of the past 12 months? 1 Yes 2 No 9 Cannoth of the past 12 months? 1 Yes 2 No 9 Cannoth of the past 12 months? 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendin Investig 3 Suicide 6 X Could or determined the past 12 months? 29a. Certifier 1 Certifying Physical Could or determined the past 12 months? 29b. Signature and title of certifier 30. Name and address of persor we hack the past 12 months? | a. ALCONOI ar Due to (or as a col b. Due to (or as a col c. Due to (or as a col d. X AMENDED 27 23c. If yes, out 1 Live birth 4 Pregnant 9 Unknown ns contributing to de Hospital: 1 Inpa 28a. Date of (Month, bs gation not be ined (Specify) sician: To the best or mer: On the basis of e and manner state the completed cause of ty Chief Medical | nsequence of): nsequence of): nsequence of): 28a-f. per come of pregnancy at time of death eath but not resulting thinging 28b 20/2008 Fr fingury - At home, found at h fingury hy, Year) fingury - At home, found at h fingury - A | ME. g87 2 Fet 5 Othors in the u Outpatient Time of Ir and 11:(farm, streethome eath occur investigat | 26.Place of the control of the contr | Ectopic pregiction of Death (Checother Nurs and | 23e. Did to the cauda auto perfix to perfect to perfix to perfect to perfix to perfect to perfec | 23d. Date of Month s 2 No 3 an psy primed? 2 No Residence 6 how injury occu (Street and Num State) Hill Ave. ise(s) and manner and place, and | ber or Rural F Apt BN er as stated, due to the canned (Month, | Year cause of death? 4 Unknown y findings available idetion of cause of 2 No ene Route Number, City Hagerstown use(s) |

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| | Physic | ian | 1. Decedent's Name (First, Middle, La | , | Fav | Sanco | tta-Am | mann | | 2. Date of D Month Februa | D | ay | Year | 3. Time of De | eath |
| | /Medi | | 4a. Facility Name (If not institution, given | | ray | Dallso | | | Location of Dea | | | c. County | | 9:30 | P |
| | Exami | ier | Holy Cross Hospi | | | | | | Spring | | | | | ** | |
| | Funeral | | 5. Social Security Number 6. S | Sex 7. Ag | e (In yrs. I | last birthda | y) If Under | 1 Year | If Under 24 Hr | s. 8. Date of B | irth | Monto | 9. Birthp | lace (State or F | oreig |
| ы | Director | | 228-82-9801 | I□M 2XIF | 55 | Yrs. | Months | Days | Hours Mir | Mar 1 | , 19 | 52 | Couir Wash | ington, | D |
| | P | | Usual Residence of Decedent | | | | | | | | | | | | |
| | trylar show | _ | 10a. State 10b. County | | 10c. City | , Town or | Location | | | | | | 1 | I Od. Inside City L | |
| | e Ma Ba-f s | cto | MD Montgom | ery | Bur | tonsv | ille | | | | | | | 1 🗌 Yes 2 | ₩ |
| | or 2 | Director | 10e. Street and Number | | | | 10f. Zip | Code | | | 10g. C | itizen of V | Vhat Cour | ntry? | |
| | 72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at | <u>ra</u> | 4330 Sandy Sprin | | | | | 866 | | | | S.A. | | | |
| | tems | Funeral | 11. Marital Status | 12. Was Decedent I Armed Forces? | Ever in U. | S. 1; | Was Deced If Yes, spec | ent of H ify Cuba | ispanic Origin? (an, Mexican, Pue | Specify Yes or Nerto Rican, etc.) | 10- | | e - Americ k, White, | ean Indian, etc. | |
| 36 | or i | by F | 1 ☐ Never Married 2 ☒ Married | Armed Forces? 1 ☐ Yes 2 1 If Yes, Give | No | | 1 ☐ Yes 2 | XX No | Specify: | | | Specify | ″ Whit | | |
| 00 | houn tural' | d b | 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E | Year or Dates: | | 16a Day | edent's Usua | I Occur | ation | | 10h | 1 | | | |
| 15 | "na" "na" edlc | lete | (Specify only highest gr | | , il | (Gi | ve kind of wor . DO NOT us | k done | during most of w | orking | 100. | Kind of Bu | 15111625/111 | dustry | |
| 21215-0036 | filed within Hygiene. Ither than " | Ę | Elementary/Secondary (0-12) | College (1-4or 5 | i+) | | | | y Suppor | t. | Ba | nkino | ז | | |
| d 2 | filed Hygi ther | Be Completed | 17. Father's Name (First, Middle, Last |) | | | | | | ame (First, Middi | | | | | |
| Maryland | 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the ME | To B | William Madison | Lawrence | | | | | Lutrel | l Mitto | na | | | | |
| Z | should ind Men imarke | F | 19a. Informant's Name/Relationship | | | 19b. Ma | iling Address | (Street | | | | or Town, | State, Zip | Code) | |
| | iges 1 and 2 should be filed within 72 hours after death with the Marylar to f Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | | William H. Amman | n /spouse | | 433 | Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Sandy Spring Rd., Burtonsville, Maryland | | | | | | yland 2 | 080 | |
| <u>ම</u> | f Heal | | 20a. Method of Disposition | , + | 20b. P | lace of Dis | position (Nam | e of | | Date | | | | own, State | |
| 9 | t. Pa rtmer rtant: njury | 1 | 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (<i>Speci</i> | | - 1 | | • | • | i i | 19, 08 | 04 | entor | n. Ma | ryland | |
| Baltimore, | | | 21. Signature of Funeral Service Lice | 1 | 1111 | | 22. Name an | d Addre | ss of Facility | | | | - | | |
| ñ | Depa Impo any I | | A LITTER ST. | | M007 | 73 | Donald 313 Ta | son 1bot | Funeral t Ave. | Home, laurei, | P.A. Mar | vland | 1 207 | 07-4389 | |
| | Physician /Medical Examiner | Examiner | 23a. Part1. Ent dease, or conshock, or entillure. List only Immediate Councillure. List only Immediate condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | a. Metasta Due to (or as b. Due to (or as | a consequ | Gliob uence of): | | | | | | | | Approximate Interval Betwee Onset and Dea | ith |
| κ 68760, | ortificate be executed ing physician and as the burial-transit | Medical Exa | resulting in death) Last IF FEMALE: | Due to (or as | | | | | | | | | | | |
| P.O. Box | law requires that the death ce as been signed by the attendir 2 should be detached for use | Physician/I | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | 2 Fetal | death 3 | 3 □Ectopic pro 5 □ Other (sp | | | | | | te of delive | ery Day Yea | ar . |
| | w requires that been signed should be det | þ | Part II. Other significant conditions | contributing to death b | ut not resu | ulting in the | underlying ca | use giv | en in Part I. | | | use cont 2 No | | he cause of dea pably 4 ⊠Unk | |
| or Vital Records, | The ate h page | Completed | | | | | - | | | per | s an opsy formed? 2 X N | | Were auto prior to co death? 1 □ Yes | ppsy findings ava mpletion of caus | ilabl se of |
| /ita | Physician: The this certificate ral director, pag | Be (| 25. Was case referred to medical examiner? | | | | | | 26. Place of De | eath (Check only | one) | | | | |
| 7 | Physic this ce al dire | 은 | 1 ☐ Yes 2 ☒ No | Hospital: 1 🔀 Inpatie | ent 2 🗌 | ER/Outpat | ient 3 □ DO | A Oth | er: 4□ Nursing | Home 5□Re | sidence | 6 □Oth | er (Specil | fy) | |
| Division o | ling I. After fune | | 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigatio | | y Year) | 28b. Time Injury | М | | yat k? Yes 2 □ No | 28d. Describe | e how inj | ury occur | red | | |
| Divi | in Dir | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | building, et | c. (Specify | /) | | | | City or T | own, Sta | ite) | | al Route Numbe | r, |
| | To the Hospital within 24 hours a To the Funeral Completely filled | Medical | (Check only 2 Medical Exa | nysician: To the best miner: On the basis of and manner sta | f examinat | | investigation, | in my o | ppinion, death oc | | | | | | |
| | Vith To t | Σ | 29b Storature and title of certifier | 107- | | | | | e number | | | ate signe | | Day, Year) | |

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene 2 U 0 8

| | • | For Stete Registrar | State of Maryland / Dep Ce | rtificate of Death | Reg. No. | | | | |
|--|---------------------|---|---|---|---|--|--|--|--|
| Physicia /Medic | an | 1. Decedent's Name (First, Middle, Last George | | C 00 - | 2. Date of Death Month Day February 14 | Year 2008 69:43 AM | | | |
| Examin Funeral Director | er | 4a. Facility Name (If not institution, give The Johns Hopkins 5. Social Security Number 6. Se 231.70.8915 | Hospital | 4b. City, Town, or Location of Death Baltmole Cty If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Country) Arcentina | | | |
| 0 | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Town or L | ocation | 04.16.1949 | 10d. Inside City Limits | | | |
| within 72 nouts after death with the Maryland then "natural", or items 23s or 28e-f show the Medical Examinar must be notified at | rector | VA Albema 10e. Street and Number | rle Earlys | SVille 10f. Zip Code | 10g. Citizen o | 1 ☐ Yes 2₹ No of What Country? | | | |
| Department of Health and Mental Hygiene. Importent: If Item 27 Ie marked other than "natural", or Items 23a or 28e-f ehow ery Injury or other traumatic event, the Medical Examinat must be notified at once. | by Funeral Director | 4540 Shagbark 11. Marital Status 1 Never Married Married Married Married Divorced | Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: | 22936 Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto F | Rican, etc.) B | .A. ace - American Indian, lack, White, etc. city: White | | | |
| iene. 'then *netur ite Medicel | Completed | 15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) | le completed) (Give | ident's Usual Occupation is kind of work done during most of workin DO NOT use ratired) Caiser | 9 | 16b. Kind of Business/Industry Real Estate | | | |
| Mental Hyg arked other atic event, | To Be C | 17. Father's Name (First, Middle, Last) Robert Shoffne | | Noemi G | (First, Middle, Maiden Sum abriela May | yer | | | |
| int of Health and it: If item 27 Ie m y or other traum | | 19a. Informant's Name/Relationship (T) Connie Shoffner 20a. Method of Disposition 1 □ Burial Coremation 3 □ II □ Donation 5 □ Other (Specify, | /Wife 4540 Removal from State 20b. Place of Disp cemetery, cree | matory or other place) | Earlyille 20c. Locatio | VA 22936 n - City or Town, State | | | |
| Departme Importeni eny Injury | | 21. Signature of Funeral Service Licens | Chesape Wolfy3 | eake Crem. 02.1 2. Name and Address of Facility CAF PA, 8717 Green P | 9.07 Belt A/Stephen l astures Dr | sville, MD D. Lohrmann . Balto.,MD | | | |
| Medical burial-transit the purial-transit | dical Examiner | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in dealh) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | ۸ | T-cell lymphoma | | Approximate Interval Between Onset and Death 男 Mon h | | | |
| been signed by the ettending phy should be detached for use as th | by Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | | □Ectopic pregnancy □ Other (specify) | | Date of delivery Month Day Year | | | |
| itte taw requires thet he beath centrication ate has been signed by the ettending bage 2 should be detached for use as | ed by Ph | Part II. Other significant conditions co | ntributing to death but not resulting in the | underlying cause given in Part I. | | e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown | | | |
| certificate hes bei irector, page 2 sho | Completed | | | | 24a. Was an autopsy performed? 1 Yes 2 No | b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No | | | |
| 0 0 | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatie | 26. Place of Death | (Check only one) | Other (Specify) | | | |
| r death. ctor: After by the fune | Certification: 1 | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred | | | | | | | |
| within 24 hours after to the Funerel Dir. | Medical Ce | 29a. Certifier 1. Certifying Phy (Check only one) | sician: To the best of my knowledge, dea iner: On the basis of examination and/or in and manner stated. | th occurred at the time, date and place, a nvestigation, in my opinion, death occurre | and due to the cause(s) and at the time, date and place | manner as stated. se, and due to the cause(s) | | | |
| | D | | | 29c. License number | 29d. Date sig | 29d. Date signed (Month, Day, Year) February 14, 2008 | | | |
| within To the | Med | 29b. Signature and little of certifier Ruft Mines | Medical Doctor | Res -000 | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

| | _ | For State Registrar | State of Maryland | - | rtificate of D | | | g. No. 2 1 1 8 | 3. Time of Death |
|--|------------------------|---|--|------------------------------------|---|-----------------------------------|---|--|---|
| Physic /Medi | | Decedent's Name (First, Middle, La Narmadaben Amrat | lal Surti | | | | Month | Day Year 7 15, 2008 4c. County of Dear | 2:50 P M |
| Exami | ner | 4a. Facility Name (If not institution, given 10108 Pasture Gas, Social Security Number 6. | | ast birthday) | | a If Under 24 Hrs. | 8. Date of Birth (Month, Day, | Howard 9. Bir | inplace (State or Foreign |
| Funeral Director | | | 1□M 2√2F 88 | Yrs. | Months Days | Hours Min. | Jan. 1 | | dia |
| e Maryland Ba-f show tiffied at | Director | 10a. State 10b. County Maryland Howard | | y, Town or Lo | | | 11 | 0g. Citizen of What C | 1 Tyes 2 No |
| EXAMPLE OFCE, INIGITY IGITIC A. I.S. 13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at | by Funeral Dire | 10108 Pasture Ga 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced | 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 1 No If Yes, Give Year or Dates: | | 21044 Was Decedent of His If Yes, specify Cubar | | ecify Yes or No- Rican, etc.) | | _{te, etc.} an Indian |
| Z I Z I 3-0030 ed within 72 hours af gjene. er than "natural", or t, the Medical Exami | To Be Completed | 15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 2 | Education rade completed) College (1-4or 5+) | (Give | dent's Usual Occupa e kind of work done d DO NOT use retired) emaker | uring most of work | | Own Home | |
| Maryland A 1d 2 should be filed Ith and Mental Hygi 27 is marked other r traumatic event, i | To Be C | 17. Father's Name (First, Middle, La: Chaganlal Darje | ee | 19h Maili | | 18. Mother's Name | n Darjee | | Zip Code) |
| re, Iviai 1 and 2 sh Health and tem 27 is m other traum | | 19a. Informant's Name/Relationship Sheela Luhar 20a. Method of Disposition | Daughter 20b. | 1010 | 18 Pasture osition (Name of ematory or other place | Gate La | ne; Colu | mbia, MD 2 | r Town, State |
| Baltimore, permit. Pages 1 a Department of Het Important: If item any Injury or othe | | 1 Burial 2 Scremation 3 4 Donation 5 Other (Spe | Cify) M Censee | etro C | Crematory 22. Name and Addres Funeral H | 2/18 ss of Facility Stome of C | erling A atonsvil | siton Schu le, Inc. tonsville | MD 21228 |
| 68760, (Medical Examine Examine g physician and as the burial-transit | Examiner | 23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consect to Due to (or according to Due to | quence of): Q R & W A quence of): | NE HEAR | T FAIL | OF TESTITUTE OF THE STREET | est, | Approximate Interval Between Onset and Death FEW M.N.TIF. |
| Box 6 Box eath certification of the control of the certification of the | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome pf pregr 1□Live birth 2□Fe 4□Pregnant at time of 9□Unknown | tal death 3 | B Ectopic pregnancy Cother (specify) | / | | 23d. Date of o Month | Day Year |
| cords, P.O. w requires that the de been signed by the s should be detached | ۾ | Part II. Other significant condition | s contributing to death but not re | esulting in the | underlying cause giv | ren in Part I. | 23e. Did t | Yes 22No 3□ | e to the cause of death? Probably 4 □Unknow |
| Records, The law requires t ate has been signe | Completed | | | | | | 1□ Yes | psy prior ormed? death 2∕XNo 1 □ Y | |
| ita lan: ertifica ctor, | Be | 25. Was case referred to medical examiner? | Heavitali | | Ott | | ath (Check only | | |
| on or Vital Red ding Physician: The lav After this certificate has funeral director, page 2 | n: To | 1 Yes 2 No | Hospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year) | ER/Outpat 28b. Time Injur | e of 28c. Inju | 4 🗆 Nursing i | | dence 6 Other (S | респу) |
| Division or Vital or attending Physician: 1 after death. I Director: After this certificat of in by the funeral director, p | ertificat | 2 Accident Investige 3 Suicide 6 Could n 4 Homicide determin | of be ned 28e. Place of injury - At building, etc. (Spec | сиу) | | | City or To | wn, State) | Rural Route Number, |
| DIVISION To the Hospital or Attendle within 24 hours after death. To the Funeral Director: A completely filled in by the fu | Medical Certification: | 29a. Certifier 1 certifying (Check only one) | Physician: To the best of my k examiner: On the basis of exami and manner stated. | nowledge, de ination and/or | r investigation, in my | opinion, death oct | e, and due to the curred at the time | e cause(s) and manne , date and place, and 29d. Date signed (M | |
| To th withir To th | Me | 1 |) | | 29c. Licen | 62634_ | | 02/16/200 34 MD 2 | i S |
| 5 | | | who completed cause of death (If A W I O & U 2 | L Hic | pe, Print) Kody RIDO | E RO | COLUM | Se mo 2 | 2/644 |
| Rec | State istra | | 008 Parisiral s Signal | * | acks. | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** February & Lovo 4. County of Death ristopher /Medical 4a. Facility Name (If not institution, give street and number Examiner Baltimore Baltimore Harbor 05 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday, **Funeral** Months Days Hours 1 X M 2 □ F 59 217 46 3452 03/30/1948 Marvland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 X Yes 2 □ No Director N/A Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 408 Frankle Street 21225 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Foldes:
1 Types 2 No
If Yes, Give
Year or Dates: Viet Nam 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welder Baltimore Dry Dock 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (not available) John Howard Seifert Edna ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21225 408 Frankle Street Geraldine Hall / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MD State Veteran Cem; 02/13/2008 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signat of Fur eral Service Ligensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a cons quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical attending pr IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 🗌 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Onknown 1 Yes 2 No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 ☐ Yes 2 ☐ No certificate or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 2 No 2 ▼ER/Outpatient 3□ DOA 1 🔲 inpatient ₽ After this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death.

To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

FEB 20

2008

DHMH 17 Rev 1/2001

th Hanover Street BALTIMORE, MD2122:

address of person who completed cause of death (Item 23a) (Type, Print)

32/Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** GEORGE McCLELLAN SHATZER, JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CARROLL HOSPITAL CENTER WESTMINSTER CARROLL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months **X** M 2 □ F Director 219-74-6317 49 12/08/1958 PENNSYLVANIA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 ☐ No MD CARROLL WESTMINSTER Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 58 BOND ST. 21157 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ^{2 N} 1977 within 72 hours after Yes 2 Yes, Give 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 Specify: 3 Widowed 4 Divorced WHITE Year or Dates: 1980 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SHIPPING & RECEIVING MANUFACTURING 12 filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental pe GEORGE McCLELLAN SHATZER, SR MARGARET 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau JUDI A. SHATZER - WIFE 58 BOND ST., WESTMINSTER, MD altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ALL COUNTY CREMATION 2/21/08 | SYKESVILLE, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 254 E. MAIN ST., WESTMINSTER, MD 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due lo (or as a consequence of): Examiner certificate be executed NEUTROPENIA physician and s the burial-trans Due to (or as a consequence of): Box 68760, CHEMOTHER Physician/Medical as attending p IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) o 9∏Unknown 9 Unknown signed by i ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ ONSMALL -CEUL LUNG 21210 1 🗌 Yes 3 Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? /es 2 No page certificate 1∐ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient P 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending (Month, Day Year) Injury Natural 5 Pending М 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 02-18-08 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
FRANCIS KHOO, MD 200 MEMORIAL AVE, WESTMINSTER, MD 2115 MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar

| | | | _ FOI | epartment of Health and N Ce <i>rtificate of Death</i> | | ene 008 05071 |
|---------------------|---|----------------|--|--|---|---|
| - CA | · 中心中 · · · · · · · · · · · · · · · · · | = | Decedent's Name (First, Middle, Last) | | 2. Date of Death Month | Day Year 3. Time of Death |
| | Physici /Media | | Gaston F. Silva | | February | ' M |
| A 30 | Examir | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death |
| | | 2. B | Suburban Hospital | Bethesda | | Montgomery |
| | Funeral | - 5 | 5. Social Security Number 6. Sex 7. Age (In yrs. last birth | Months Days Hours Min | 8. Date of Birth (Month, Day,) | 9. Birthplace (State or Foreign Country) |
| | Director | | 251-74-9327 | s | June 16, | |
| | and w | | Usual Residence of Decedent 10a, State 10b, County 10c, City, Town | or Location | | 10d. Inside City Limits |
| | f eho | ō | Maryland Montgomery Rockvi | 11e | | XXYes 2 □ No |
| | 28a- | Director | 10e. Street and Number | 10f. Zip Code | 100 | g. Citizen of What Country? |
| | ours after death with the Maryland rai', or items 23a or 28a-f ehow Exartinat must be rollited at | 0 | 1420 Thornden Road | 20851 | | Chile |
| | ms 2; | era | 11. Marital Status 12. Was Decedent Ever in U.S. | 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto | pecify Yes or No- | 14. Race - American Indian, |
| (0 | | Funerai | 1 Never Married MXMarried Armed Forces? 1961— | If Yes, specify Cuban, Mexican, Puerto | | Black, White, etc. |
| 9 | hours after tural', or ite | by | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates: 1963 | 1ttrYes 2∐ No Specify: 01112 | 10411 | Specify: WILLE |
| Maryland 21215-0036 | 2 8 3 | Completed | 15. Decedent's Education 16a. C (Specify only highest grade completed) (| ecedent's Usual Occupation Give kind of work done during most of work | king 16 | 6b. Kind of Business/Industry |
| 21 | within then then then then then then then the | npi | Elementary/Secondary (0-12) College (1-4or 5+) | ife. DO NOT use retired) | | nternational Affairs |
| 2 | ygier th | Co | | uments Officer | | |
| <u>n</u> | tal H | Be | 17. Father's Name (First, Middle, Last) | | ne (First, Middle, Ma | aiden Sumame) |
| Ž | d 2 should be filed within "h and Mental Hygiene." 7 is marked other then "traumatic event, the Mer | 은 | Victor Silva | 01ga | Farina | Charles To Control |
| Ja | l 2 sh and r ls n | ΡÏ | | Mailing Address (Street and Number or Rui | | |
| e) | l and Health | | | O Thornden Rd., Roc | | Maryland 20851 Oc. Location - City or Town, State |
| Ď | iges if of the | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, | crematory or other place) Febr | ruary | |
| Baltimore, | permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra | | | ery Crematorium 16, | | Bethesda, Maryland |
| Bal | Department of the partment of | | | | | Home/Rockville, Inc. |
| | 40100 | | M00877 23a. Part. Enter the disease, or comblications that caused the death. Do no | 300 West Montgomery | | |
| | | ķ i | shock, or heart failure. List only one cause on each line. | | | Interval Between Onset and Death |
| | Physician /Medical | ļ. | resulting in death) | ive Ventilatory Def | Eect | Years |
| | Examiner | | Due to (or as a consequence of | : | | |
| | | 5 | Sequentially list conditions, if any, leading to immediate b. | V | | |
| | nsit | Examiner | cause. Enter Underlying Cause (Disease or injury | | | |
| <u>,</u> | be executed ician and burial-transit | Exa | that initiated events resulting in death) Last C. Due to (or as a consequence of | :: | | |
| 8760, | | dical | d | | | |
| .89 | ificate g physi as the l | edic | | | | |
| Вох | eath certifica attending ph I for use as th | M | IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death | 3 Ectopic pregnancy | | 23d. Date of delivery |
| | death of attented for u | Physician/Me | in the past 12 months? 4 Pregnant at time of death | 5 Other (specify) | | Month Day Year |
| P.O | that the de ed by the detached | hys | 9 ☐ Unknown | | | |
| | res that igned by be deta | ру Р | Part II. Other significant conditions contributing to death but not resulting in t | ne underlying cause given in Part I. | 23e. Did toba | acco use contribute to the cause of death? |
| Ë | w requires been sign should be | ed | | | 1X Yes | s 2 No 3 Probably 4 Unknown |
| သို့ | > 0 % | Completed | | | 24a. Was an autopsy | |
| Œ. | The law ate has page 2: | E O | | | perform | |
| ita | iician: Th certificate rector, pag | Bec | 25. Was case referred to medical examiner? | 26. Place of Dea | th (Check only one | |
| of Vital Records, | Physician: r this certific ral director, | 70 E | 1 ☐ Yes 2 1 No Hospital: 1 ☐ Inpatient | atient 3 DOA Other: 4 Nursing H | ome 5 Residen | nce 6 ☐Other (Specify) |
| 0 | | | 27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year) 28a. Date of Injury (Month, Day Year) | | 28d. Describe how | w injury occurred |
| ō | ending eath. or: Afte. he fune | atic | 2 Accident investigation | M 1 Yes 2 No | | |
| Division | r Att | Certification; | 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Ptace of Injury - At home, farm building, etc. (Specify) | 1, street, factory, office | 28f. Location (Stree City or Town, | eet and Number or Rural Route Number, State) |
| | itai o irs af rat D led ir | Č | | | | |
| | Hosp 4 hou Fune ely fil | edicai | 29a. Certifier (Check only (C | death occurred at the time, date and place, or investigation, in my opinion, death occu | , and due to the cat rred at the time, dat | use(s) and manner as stated. te and place, and due to the cause(s) |
| | To the Hospital or Attence within 24 hours after death To the Funeral Director: completely filled in by the | Med | one) and manner stated. | | | d. Date signed (Month, Day, Year) |
| | To To Cor | | 29b. Signature and title of certifier | 29c. License number | | |
| , | | 111 | Jon D | 044123 | F | February 13, 2008 |
| 1 | 011/ | | 30. Name and address of person who complete case of death (Item 23a) (TIra Berger, M.D., 1201 Seven Locks | | 1a Marul | Land 20854 |
| | | | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | Mue, HIII, MUCKVII | re, maryı | Luiid 20057 |
| 24 | Sta Registr | | FEB 2 0 2008 | general of | | |

BE

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Cecelia Thomas 16,2008 enruary /Medical Ac. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A 12 Mer turoro 7. Age (in yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex **Funeral** ate of Birth Month, Day, Year) 1 □ M 2 □ Months Davs Hours Min Maryland Director 62 Mar 30, 1945 212-46-2933 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits 10b. County 28a-f show iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐¥es 2 ☐ No Baltimore Director Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 U.S.A 740 Poplar Grove Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Yes 2 Your Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ **X**0 Specify Black þ Specify. 3 Widowed 4 Divorced 'natural', Completed 16a. Decedent's Usual Occupation other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Maryland Cup Factory **Employee** Pages 1 and 2 should be filed v nent of Health and Mental Hygie int: If item 27 Is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fentress Thomas Willie Evans ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Wheeler Avenue Baltimore, Maryland 21223 Fenell T. McDonald 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages ' Department of h Important: If it any injury or o 1 ☐ **9**Urial 2 ☐ Cremation 3 ☐ Removal from State Lansdowne, Maryland 02/23/08 Mt. Zion Cemetery 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a con, eq., nce of): Examiner Shoc Esquentiary liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed otice mia Due o (or as a consequence of): burial-Box 68760, physician Physician/Medical the attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) ed by the a detached f P.O. 1 ☐ Yes 2 ☐ No 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division or Vital Records, þ 2 No 3 Probably 4 Dunknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an has autopsy performed? page this certificate 1□ Yes 2 **1** Mo or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA P funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 5 Pending investigation (Month, Day Year) Injury 1 Natural within 24 hours after use..... To the Funeral Director: After the function of 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month) Day, Year)

Ohilv

FEB 20

30. Name and address of person who completed cause of death (Item 23a) (Type, Prin

2008

32 Registrar's Signature

the Hospital

DHMH 17 Rev 1/2001

1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

| | | Plea | se Type or | | | | | | | | _ | ible. | |
|--|-------------------|--|---|---|---------------------------------|------------------------------|-----------------------------|-----------------------------------|-------------------------------|----------------------------------|----------------------------|---------------------------------------|---|
| | | 1 - For State Registrar | State o | f Marylar | | artment <i>rtificate</i> | | | l Menta | , 0 | ne . _{No.} 2 (| 008 | 05074 |
| Physicia | an | 1. Decedent's Name (First, Middl | | | | | | | 2. Date Mor | e of Death nth | Day | Year | 3. Time of Death |
| /Medic | | ROBERT | EUGE | | WILI | IAMS, | | | | ruary | | 2008 | 12:30 P M |
| Examin | er | 4a. Facility Name (If not institution 806 Regester | Avenue | | | Ва | ltim | | | | 4c. Count Balt | imor | e County |
| Funeral Director | | 5. Social Security Number 219-18-5836 | 6. Sex 1 ↑ M 2 □ F | 7. Age (In yrs. 81 | Yrs. | If Under Months | Days | Hours Mi | n. (Mo. | e of Birth onth, Day, Y 10 , | ^{ea} r) 1926 | Co | hplace (State or Foreign untry) ryland |
| Maryland a-f show ified at | ctor | Usual Residence of Decedent 10a. State 10b. County Maryland Balti | more Coun | | ty, Town or Lo | cation timore | 2 | | | | | | 10d. Inside City Limits 1 ∐Yes 2∰ No |
| with the | I Director | 10e. Street and Number 806 Regester A | | | | 10f. Zip | Code | 239 | | 10g | . Citizen of | What Co | untry? |
| death ms 20 | Funeral | 11. Marital Status | | edent Ever in U | | Was Deced | ent of His | panic Origin? | (Specify Ye | s or No- | 14. Ra | ice - Ame | rican Indian, |
| ours after al', or ite Examine | þ | 1 ☐ Never Married 2 💥 Mar 3 ☐ Widowed 4 ☐ Divorced | | 2□No WW | TT | 1 ☐ Yes 2 | | i, Mexican, Pue Specify: | eno Alcan, e | etc.) | Speci | ack, White ify: [/ | , etc. √hite |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | Completed | 15. Deceder (Specify only higher Elementary/Secondary (0-12) | t's Education st grade completed) | -4or 5+) | (Give | DO NOT us | k done di e retired) | ıring most of w | | B | b. Kind of E | ore | City |
| il Hygie other t ent, th | e) | 17. Father's Name (First, Middle, | Last) | | C1V1. | . Dere | | Enginee 18. Mother's N | | | ivil iden Surna | | ice |
| ould be Menta narked natic ev | To B | Robert Eugene | | , Sr. | | | | Lillia | | | | | |
| nd 2 sh alth and 27 is m r traum | | 19a. Informant's Name/Relations Mrs. Patricia I | | s (Wife | 1 | _ | | nd Number or . Aszenije | | | - | | d 21239 |
| ges 1 a t of Hea If Item or othe | | 20a. Method of Disposition 1 X Burial 2 ☐ Cremation | | 20b. | Place of Dispo cemetery, cre | sition (Nam | e of |) | Date | 20 | | | Town, State |
| nit. Parartmen ortant: Injury | | 4 ☐ Donation 5 ☐ Other (5 | 7 | Mo | reland 2 | 2. Name and | Address | of Facility | 3/2008 | | | | Maryland |
| Dep lmp | | Martin D. 9 | awson | , | N | IITCHE 500 Y | LL-W ork | IEDEFEI Road, F | Baltim | ore, | Maryl | INC and | 21212 |
| Physician /Medical Examiner | | 23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) | only one cause on e | aused the dea ach line. Tu 5 Tull or as a consec | ic Pa | NCT 66 | 1 | Λ. [| MoCa | | | | Approximate Interval Between Onset and Death Amonth |
| e executed an and Arial-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | с | or as a consector as a consector | | | | | | | | | |
| cate be physici the bu | dical | | d | | | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physiciar completely filled in by the funeral director, page 2 should be detached for use as the buring the funeral director. | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | | oirth 2 Fet nant at time of | al death 3 | ⊒Ectopic pre ⊒ Other (spe | | | | | | ate of del fonth | ivery Day Year |
| quires that in signed buid be deta | | Part II. Other significant conditi | ons contributing to de | eath but not res | sulting in the L | inderlying ca | use give | n in Part I. | 23 | e. Did tobae | | | the cause of death? |
| sician: The law re certificate has bee irector, page 2 sho | Completed by | | | | | | | | - _ | a. Was an autopsy performe | | were au prior to death? 1 ☐ Yes | utopsy findings available completion of cause of |
| an: ' | Be C | 25. Was case referred to medica | 1 | | | | | 26. Place of D | | / | O IAO | 1 1 162 | 20110 |
| nysician: nis certific director, | To B | examiner? 1 ☐ Yes 2 No | Hospital: 1 🔲 | npatient 2 |] ER/Outpatie | nt 3 🗆 DO. | A Othe | r: 4 🗆 Nursing | Home 5 | Residen | e 6 □0 | ther (Spe | cify) |
| nding Pł ath. r: After the e funeral | | 27. Manner of Death 1 Netural 5 Pendir 2 Accident investi | 9 | of Injury th, Day Year) | 28b. Time of Injury | of 28 | Bc. Injury Work 1 ☐ Y | at ? es 2 □ No | 28d. De | escribe how | injury occu | urred | |
| To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director. | Certification: | 3 Suicide 6 Could 4 Homicide determ | ined Zee, Place | of injury - At h | ome, farm, st | reet, factory | office | | | cation (Stre y or Town, | | nber or Ru | ural Route Number, |
| ne Kospi 124 hour ne Funer pletely fill | Medical | 29a. Certifier 1 Certifyir (Check only one) | ng Physician: To the Examiner: On the b and man | best of my kn asis of examin ner stated. | owledge, dea ation and/or in | th occurred anvestigation, | at the tim in my op | e, date and pla inion, death o | ace, and due ccurred at th | e to the cau ne time, dat | se(s) and r e and place | manner as e, and due | s stated. e to the cause(s) |
| To th within | Me | 29b. Signature and title of certific | 70/ | | | 29c | License | 5 691 | 19 | 290 | Date sign | ned (Mont | h, Day, Year) |
| 10 | | 30. Name and address of person | | e of death (Ite | m 23a) (Type, | Print) | | | | | | - | |
| Sta | te | Robert Donegar 31. Date filed (Month, Day, Year, | 32. R | egistrar's Sign | ature A | E » | | | | | | | |
| Registr | | FFB 2 0 2 | 008 | 130 15 | OF THE SE | | | | | | | | |

| | | | 1 _ State | e of Maryla | _ | partment of Fertificate of | | | - / H117 | 05075 |
|-------------|--|-------------------|--|--|-------------------------------------|--|---|--|-------------------------|--|
| | | - | Registrar 1. Decedent's Name (First, Middle, Last) | | - 00 | ortineate or | Death | 2. Date of Death | g. No." | 3. Time of Death |
| | Physicia | | HARRY FULLER | יות. | ITE Jr | | | Month | 19, 2008 | 8:00a.M |
| 100 | /Medic Examin | | 4a. Facility Name (If not institution, give street an | | IIE OL | 1 | r Location of Death | 1 | 4c. County of Dea | |
| | Examin | er | 8406 Charles Valley C | · · | ot. D | Tows | on | | Baltimo | re |
| 400 | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In y | yrs. last birthda | y) If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth | 0.8 | rthplace (State or Foreign |
| ы | Director | | 21.2-20-8944 ^{1×M 2C} | ^{3 F} 84 | Yrs. | WOTHIS Days | riouis iviiii. | Feb. 28 | ,1923 Mai | cyland |
| | pu » | | Usual Residence of Decedent 10a. State 10b. County | 10c | . City, Town or | ocation | | | | 10d. Inside City Limits |
| | shoved at | 5 | | | _ | | | | | 1 ☐ Yes 2 No |
| | the N 28a-f | ect | Maryland Baltimore 10e. Street and Number | | Iowson | 10f. Zip Code | | 10 | g. Citizen of What C | Country? |
| | with 3a or 1 be r | Funeral Director | 8406 Charles Valley C | Court An | + D | 21204 | | | U.S.A. | |
| | ns 23 | era | 11 Marital Status 12. Was | Decedent Ever in | | B. Was Decedent of H | lispanic Origin? (Sp | pecify Yes or No- | 14. Race - Am | |
| 9 | after (| 3 | 1 ☐ Never Married 2 💢 Married 1 💢 | ed Forces? Yes 2 | W 11 | | | o Hican, etc.) | Black, Wh | |
| 21215-0036 | ral", c | Completed by | 3 ☐ Widowed 4 ☐ Divorced Year | r or Dates: | | 1 ☐ Yes 2 No | Specify: | | Specify: W | nite |
| 5-0 | 72 h "natu dical | etec | 15. Decedent's Education (Specify only highest grade comple | eted) | 16a. Dec | edent's Usual Occup le kind of work done . DO NOT use retired | ation during most of worl | king | 6b. Kind of Business | s/Industry |
| 121 | vithin | dm | Elementary/Secondary (0-12) Colle | ege (1-4or 5+) | | . DO NOT use retired Banker | a) | | Financ | ial |
| 42 | Hygie Hygie ther int, th | ပ္သ | 17. Father's Name (First, Middle, Last) | • | | Dainter | 18. Mother's Nam | ne (First, Middle, N | | |
| Maryland | d be sental ced o | To Be | Harry Fuller White | Sr | | | Li11i | | Dorf | 1er |
| Σ | shoul nd M marl | - | 19a. Informant's Name/Relationship (Type. Print | | 19b. Ma | iling Address (Street | | | | |
| Š | nd 2 alth a 27 Is r trat | | Mrs. Carroll White (V | Vife) | 8406 | Charles | Valley Co | ourt Apt. | D Baltimo | ore,Md. 21204 |
| re, | iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | | 20a. Method of Disposition | 20 | b. Place of Dis | position (Name of rematory or other pla | ce) | Date 2 | 20c. Location - City o | r Town, State |
| Ē | Page nent o | | 1 ☐ Burial 2 【A Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify) | from State | | int Cremator | ! | 21-08 | Baltimore | ,Maryland |
| Baltimore, | permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any Injury or other trau | | 21. Signature of Funeral Service/Licenses | | | 22. Name and Addre | | tche11-W | iedefeld I | F.H. Inc. |
| <u>m</u> | 99 = 20 | | Chest prote | | | | | | | aryland 21212 |
| н | | | 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cause | that caused the d on each line. | death. Do not e | inter the mode of dyin | ng, such as cardiac | or respiratory arre | st, | Approximate Interval Between Onset and Death |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | | | 1PIBL | | | | SAME |
| | /Medical Examiner | | Di | ie to (or as a cons | sequence of): | PY ARTA | ERY DI | 55182 | > | 16925 |
| | 3.58 | -a | Sequentially list conditions, b. Du frank, leading to immediate | ue to (or as a cons | · | / / | . , | | | |
| V | uted d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. | | | | | | | |
| 0, | ate be executed ohysician and the burial-transit | Еха | resulting in death) Last | ue to (or as a cons | sequence of): | | | | | |
| 8760, | tte be nysicia ne bu | dical | d | | | | | | | |
| 9 | rtifica ng ph as th | Med | IF FEMALE: | | | | | | | |
| Box | ath ce ttendi or use | an/I | 23b. Was decedent pregnant in the past 12 months? | s, outcome pf pre Live birth 2 □ F | Fetal death 3 | B □Ectopic pregnanc | у | | 23d. Date of d Month | elivery Day Year |
| 1.0 | The law requires that the death certific tte has been signed by the attending p tage 2 should be detached for use as | Physician/Me | 1 T Ves 2 T No 4 | Pregnant at time Unknown | of death 5 | 5 ☐ Other (specify) _ | | | World | buy (vai |
| P.0 | that the | Ph | Part II. Other significant conditions contributing | to death but not | resulting in the | underlying cause giv | ren in Part I. | 23e. Did tob | acco use contribute | to the cause of death? |
| Records, | signe d be | Completed by | | , | Ü | , , | | 1 | s 2 i No 3 □ 1 | Probably 4 Unknown |
| Sor | v requ | etec | | | | | | 24a. Was ar | 24h Were | autopsy findings available |
| Re | sician: The law requir certificate has been si rector, page 2 should | du | | | - | | | autops | prior to | completion of cause of |
| Vital | in: T ifficate or, pa | | 25. Was case referred to medical | | | | 26 Place of Dec | th (Check only one | 1 Ye | es 2 No |
| > | ysicia s ceri | o Be | examiner? 1 Yes 2 Z No Hospital: | 1 ☐ Inpatient 2 | 2 ER/Outpati | ent 3 DOA Oth | er. | . / | nce 6 □Other (Sp | necify) |
| 0 | g Ph ter thi neral | Li | | Date of Injury (Month, Day Year | 28b. Time | | | 28d. Describe ho | | , |
| Ö | Attending Physician: r death. ector: After this certific. by the funeral director, | atio | 2 Accident investigation | (World), Day Year | ., ., | | Yes 2 □ No | | | |
| Division or | ir Atte | Certification: To | 3 ☐ Suicide 6 ☐ Could not be determined 28e. | Place of injury - A building, etc. (Sp. | At home, farm, : pec <i>ify)</i> | street, factory, office | | 28f. Location (Str. City or Town | | Rural Route Number, |
| | urs afteral o | | | | | | | | | |
| | To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page. | Medical | 29a. Certifier 1 Lertifying Physician: 7 (Check only one) 2 Medical Examiner: On and | the basis of my the basis of exan I manner stated. | knowledge, de mination and/or | investigation, in my | me, date and place opinion, death occu | r, and due to the ca irred at the time, d | ate and place, and d | as stated. ue to the cause(s) |
| | Го the within Го th сотры | Me | 29b. Signature and title of certifier | 1 | | 29c. Licens | e number | 25 | d. Date signed (Mo | nth, Day, Year) |
| | | | Mars X | · Carr | uscal | _ DC | o 137 | 3 | 2 19 | CS |
| | 0 | 1 | 30. Name and address of person who completed | | | | | | | |
| | ¥ | | Francis X. Carmody, | MD 750 | 05 Osle | r Drive To | owson,Mar | yland 21 | 204 | |
| | Sta Registr | _ | 31. Date filed (Month, Day, Year) FFR 2 0 2008 | 32. Registrar's Si | signature | A STATE OF THE STA | | | | |
| | negisti | a, | FLD & 0 2000 | Tes 100 343 | Tras Barrell | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 2008 /Medical 4a. Facility Name (If not institution, give street and number) 3900 Lach Rage 4b. City, Town, or Location of Death 4c. County of Death Examiner Rehabilitation Care Extended Baltimore f Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2□ F Months 219-30-9914 Director Manning Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show 1 Yes 2 No irai", or items 23a or 28a-f sh Examiner must be notified MD Director Baltimae 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21239 Noodbourne Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Black Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Scaler ACME 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wells ၉ scorara 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Hural Route Number, City or Town, State, Zip Code) Woodbourne Ave Mari Baltimore MD WI 1001 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 □Removal from State Crownsville 22/2008 rownsville 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as call shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Prostral e **Physician** leTeSIIC /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 ed by the attending physician detached for use as the buria Physician/Medical as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 2 No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 □ Yes 2 No 3 Probably 4 □Unknown Completed . Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes perform dis walk in wie To the Hospitai or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 ☐ Homicide determined within 24 hours a To the Funeral I 29a, Certifier 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year) FEB 2

30. Name, and address of person who completed cause of death (Item 23a) (Type, Print)

3900 L

| | | Registrar 1. Decedent's Name (First, Middle, Last) | | | epartmer 26,02/ Centificat | | | Ï | 2. Date of Dea | | | 3. Time of Death |
|--|---------------|---|--|-------------------------------|--|---------------------------------------|----------------------------|-------------|--|----------------------------|------------------------------|---|
| Physicia | | FARI | TALEN | TZEŁ | | | | | Month 02 | Day 122 | Year | - 00:03 M |
| /Medic | | 4a. Fecility Name (If not institution, give st. | | | 4b. City. | Town, or | Location of | of Death | | 4c. Co | unty of Deatl | h |
| | | AGH | | | | | BEK | | | | MORC | ESTER |
| uneral Director | | 103-24-000 | M 2 T E | (In yrs. last birt | hday) If Unde Months | 1 Year Days | If Under Hours | | 8. Date of Birtl (Month, Day Mar 23, | 1932 | 9. Bird Co Penr | hplace (State or Foreign untry) 1sylvania |
| * | | Usual Residence of Decedent 10a. State 10b. County | unk | 10c. City, Town | or Location | | | | | | | 10d. Inside City Limits |
| , or items 23e or 28s-f ehow eminer nast be notified at | ō | DE | | 0cean | Vi ov | | | | | | | 1 ☐ Yes 2 ☐ No |
| = | Director | DE 10e. Street and Number | | ocean | 10f. Zi | Code | | | | 10g. Citizer | of What Co | untry? |
| olical Examiner must be | | 36633 Baltimore Av | enue | | | 19 | 9970 | | | | USA | |
| 1 | Funeral | 11. Marital Status | 2. Was Decedent Ev Armed Forces? | ver in U.S. | 13. Was Dece | dent of Hi | spanic Ori | gin? (Spe | cify Yes or No- Rican, etc.) | 14. | Race - Ame Black, White | |
| | | 1 ☐ Never Married 2 🔀 Married | 1 ☐ Yes 2 🛣 No If Yes, Give | | 1 ☐ Yes | | Specify: | | , , , , , | | ecity: whi | |
| 1 | d by | 3 Widowed 4 Divorced | Year or Dates: | 100 | Danada Wa Ma | -1 0 | | | | | of Business/ | |
| | Completed | 15. Decedent's Educa (Specify only highest grade | completed) | | Decedent's Usu (Give kind of wo life. DO NOT u | al Occupa ork done d se retired | ttion luring mos) | t of workir | ng | IOD, KING | Of Dusiness/ | industry |
| | E O | Elementary/Secondary (0-12) | College (1-4or 5+) | •) | truc | | | | | trai | nsport | ation |
| | 0 | 17. Father's Name (First, Middle, Last) | | | | | | r's Name | (First, Middle, | | | |
| | 0 B | Earl T. Wentzel S | Sr | | | | M | ildre | ed Prita | Z | | |
| | . 4 | 19a. Informant's Name/Relationship (Type | | | Mailing Addres | | | | | _ | | |
| | | Nancy Wentzel/spo | ıse | | 6633 Ba | | ore A | | | | | 19970 |
| | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☒ Other (Specify) | moval from State | | Disposition (Na y, crematory or o | | e) | D | ate | 20c. Locat | tion - City or | Town, State |
| once. | | 21. Signature of Forneral Service Licenses Ronal O S W | ade, Direc | ctor | State Baltim | | - | | 655 W. | Balt: | imore | Street |
| al er | icai Examiner | resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d. | Due to (or as a | сопѕедиенсе с | of). | | | | | | | |
| | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown | Fetal death | 3 ⊟Ectopic p 5 ⊟ Other (s _i | | | | | 230 | d. Date of del Month | ivery Day Year |
| | Ď | Part II. Other significant conditions cont. OBESE COP | | _ | the underlying | ause give | en in Part I | | 1 | obacco use | | the cause of death? |
| 200 | lete | Couse, Cor. | | | | | | | 24a. Was | an s | Ah Were au | stopsy findings available |
| | Completed | | | | | | | | autop | rmed? 2124No | prior to death? | completion of cause of |
| | o Be | 25. Was case referred to medical examiner? 11 Yes 2 No | spital: | t 25 ÉR/Ou | aCl D | Othe | ar | | (Check only o | | 70ther (C | -41 |
| | tion: To | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 1 ☐ Inpatient 28a. Date of Injury (Month, Day | | | 28c. Injury Work | 4 🗀 Nu | 2 | ne 5 Resid | | | спу |
| | ertification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injur building, etc. | y - At home, far (Specify) | rm, street, factor | | | | 28f. Location (S City or Tow | | Number or Ru | ural Route Number, |
| aleiy illic | edical C | 29a. Certifier (Check only one) 1 Cartifying Physi 2 JMedical Examina | cian: To the best of ar: On the basis of e and manner state | examination and | , death occurred d/or investigation | at the tim | ne, date an pinion, dea | nd place, a | and due to the o | cause(s) an date and pl | nd manner as ace, and due | s stated. e to the cause(s) |
| completely filled in by the fu | Me | 29b. Signature and title of certifier | The state of the s | | 29 | c. License | number | | 17 | 29d. Date s | signed (Mont | TO Year) |
| | | 1 Smoth C. Th | duntly | m.s. | | 20 | 624 | / | Į. | CDLUA | ±y 3,2 = 03° | 08 |
| | | 30. Name and address of person who con | 1 | ath (Item 23a) (| Type, Print) | | | | | | | |
| | 1 | | | | | | | | | | | |
| | | 31. Date filed (Month, Day, Year) | HOLZING | ETH s Signature | M.D. | 2 | 63 - | SNOW | N STI | SNOV | VHILL, | MD, 21863 |

DOD 02/02/2008

DOB 03/23/1932

05078

| | | | 1 | 1 - State Amend Item | n 23a per dr. | ,g876 | engini Sertific | 7/08di | Death | mental Hy | /gien Reg. N | ie- | | 00070 |
|-------------------|--|---------------------|------|---|---|----------------------|-----------------------------|---------------------|---------------------------|---|-----------------|-------------|--------------|------------------------------------|
| 1 | Physic | cian | | Decedent's Name (First, Middle, La | • | | | | | 2. Date of D | eath | ay | Year | 3. Time of Death |
| | /Med | lical | ı | BERNARU, L | , WILLI | AMS | | | | FEBRUA | | | 200% | 1130 PM |
| | Exam | iner | 1 | 4a. Facility Name (If not institution, give | | | | 2 | or Location of De | | 4 | c. County | of Death | |
| | | | ۹, | MERCY MEDI 5. Social Security Number 6.5 | | | | | IMORE | | | | | |
| | Funera Director | | | 216-36-6530 6.5 | ex . 7. Age (In yr. | s. last birthi Yı | Mont | hs Days | If Under 24 H | in. (Month, D. | rth ay, Yea | 2 -(| 9. Birthpla | ace (State or Foreign |
| | | | H | Usual Residence of Decedent | 01 | | 3. | | | 05,0 | 7,10 | 138 | | 10 |
| | yland | | | 10a. State 10b. County | 10c. 0 | City, Town | or Location | | | | | | 10 | d. Inside City Limits |
| | the Marylar 28a-f ehow | į | | MD | ρ | 11:00 | more | 7 | | | | | | 1 Pres 2 □ No |
| | or 284 | rec | | 10e. Street and Number | | <u> </u> | | Zip Code | | | 10g. C | itizen of V | Vhat Countr | n/? |
| | th will | aD | | 1040 E. 33rd | St Act 22 | 5 | | ລ່າລາຍ | Q | | | 116 | : Δ | .,. |
| | 72 hours after deeth with the Maryland neturel', or iteme 23a or 28a-f ehow alcel Exacultar must be notified at | by Funeral Director | 1 | 11. Marital Status | 12. Was Decedent Ever in Armed Forces? | U.S. | 13. Was De | cedent of H | lispanic Origin? | (Specify Yes or No erto Rican, etc.) |)- | 14. Race | - America | n Indian, |
| 9 | or its | 围 | | 1 ☐ Never Married 2 ☐ Married | 1 Yes 2 Ho | | | | | erto Rican, etc.) | | Blac | k, White, et | tc. |
| 5-0036 | ural', | d b | | 3 ☐ Widowed 4 ☐ Divorced | Year or Dates: | | I L Ye | s 2□N | Specify: | | | Specify | Blo | ack |
| 5 | 72 hour | Completed | | 15. Decedent's Ed (Specify only highest gra | | 16a. D | ecedent's L Give kind of | sual Occup | ation during most of w | vorkina | 16b. | Kind of Bu | siness/indu | ustry |
| 2121 | within ene. then * | ם | - | Elementary/Secondary (0-12) | College (1-4or 5+) | 1/1 | fe. DO NO | T use retired | during most of w | - | V | 1 | | \. |
| 7 | be filed withintal Hygiene. | ပိ | - | 17. Father's Name (First, Middle, Last) | | / | VAI | nte | nance | 2 | | ohn | 1400 | Kins |
| anc | lid be f fental h rked of | Be | | A A Last | 11:000 | | | | | ame (First, Middle | Maide | n Sumam | θ) | |
| Ž | should nd Men marke | 2 | | 100 Information Name (Paristrumbia) | Iliams | | | | | nnie | H^{r} | Ц | | |
| Maryland | s 1 end 2 should f Health and Mer tem 27 ie markd other traumatic | | | 19a. Informant's Name/Relationship | ype, Pnnt) | 19b. M | failing Addr | A /A | | Rural Route Numb | | | State, Zip C | Code) |
| | s 1 en f Heal item 2 other | | 12 | DerNard Will 20a. Method of Disposition | iams, Jr. | 33 Place of Di | isposition (| VIOR | ayia k | od Balti | mo | re, n | VD e | 71914 |
| Baltimore, | 8° 2° ≥ 5 | | - | 1 Bunal 2 ☐ Cremation 3 ☐ | Removal from State | cemetery, | crematory o | or other plac | e) | Date | | | City or Tow | |
| Ē | permit. Pege Department o Important: If any injury or once. | | - | 4 Donation 5 Other (Specify | | ing | Mer | moria | 1 2 | 14 2008 | <u>6</u> | alti | nore | (IM. |
| Ba | permit. Departmit importa any inju | | - | 21. Signature of Funeral Service Licen | Thomas | ı | 22. Name | | ss of Facility V | aughn C.(Itimore | ire | 200 F | UNORC | userices |
| | | | 1 | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only | lications that caused the dea | ith. Do not | enter the m | ode of dying | g, such as cardi | ac or respiratory a | rrest. | 7 01 | | Approximate |
| | Physician | | 1 1 | mmediate Cause (Final | . / | | | | | | | | | nterval Between Onset and Death |
| 1 | /Medical | | 1 | disease or condition resulting in death) | a. TNEUM. Due to (or as a consec | | TT | | | | | | | |
| | Examiner | | | 2 | Λ | 73 | 741 | Aspir | cation H | neumonia | ı | | | |
| | n ./ = | ner | O C | Sequentially list conditions, any, leading to immediate cause. Enter Underlying cause (Disease or injury hat initiated events | b. Due to (or as a consec | | 3,0 | | | 10 27 | | | | |
| | ng | Examiner | th | Cause (Disease or injury hat initiated events | . SMALL | Bou | SEL | 0 | RSTE L | LTIOI | | | | |
| ó | e exe | | ľ | esulting in death) Last | Due to (or as a consec | quence of): | | | | | | | | === |
| 68760, | rtificate be executed no physicien and and as the burial-transit | Medical | | | d | | | | | | | | | |
| | | Med | TIE. | F FEMALE: | | _ | | | | | | -15 | | |
| Box | The law requires that the death cer tie hes been signed by the ettendir bage 2 should be detached for use | Physiclan/I | | 3b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta | -, -, | 3 □Ectopic | Oregonanov. | | | | 23d. Date | of delivery | |
| 0 | at the dea by the e | sic | | 1 Yes 2 No | 4☐Pregnant at time of c | | 5 Other | | | | | Mon | th Da | ay Year |
| P.0 | that the | Phy | - | | | | | | | | | | | |
| Ś | res the signer bed | þ | P | art II. Other significant conditions co | ntributing to death but not res | sulting in the | e underlying | cause give | n in Part I. | 23e. Did to | bacco | use contril | oute to the | cause of death? |
| oro | v requir been s should | Completed | - | | | | | | | 101 | es 2 | □No 3 | 3 Probab | oly 4 Unknown |
| ec | law 19sb 12st | ple | _ | | | | | | | 24a. Was | | 24b. W | ere autops | y findings available |
| E - | | 5 | | | | | | | | autop perfor | med2 200 No | de | ath? | letion of cause of |
| of Vital Records, | sicien: 'certifice | Be (| 25 | 5. Was case referred to medical examiner? | | | | | 26. Place of De | eath Check only o | / > | | 1105 2 | Ν̈́ο |
| 7 | hys his | ၉ | | 1 ☐ Yes 2 No | lospital. 12 har atient 2 | ER/Outpat | ient 3 🗆 🛭 | Other Other | | Home 5 ☐ Resid | 11. | 6 □Other | (Specify) | |
| | ا عَرَة حَ | ë | 27 | 7. Manner of leath 1 Natural 5 Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time Injury | | 28c. Injury Work | at | 28d. Describe h | | | | |
| Division | Attending r death. ector: After by the funer | catl | | 2 Accident investigation | | | М | 1 🗆 Y | es 2 No | | | | | |
| Ξ | trect | Certification: | | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of Injury - At he building, etc. (Specification) | ome, farm, | street, facto | ry, office | | 28f. Location (S City or Tow | treet an | d Number | or Aural A | loute Number, |
| | urs a | | | | | | | | | | | | | |
| | To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu | edical | 29 | 9a. Certifying Phy (Check only 2 Medical Exami | sician: To the best of my kno ner: On the basis of examina and manner stated. | wledge, de | ath occurre | d at the time | e, date and place | e, and due to the d | ause(s) | and man | ner as state | ed. |
| | thin 2 the mplet | Med | 200 | | and manner stated. | | | | | arrea at the time, t | ate and | piace, an | u due to th | e cause(s) |
| | Z Z Z S | - | 29 | b. Signature and title of certifier | 11 AND | | 2 | 3c. License | | | 29d. Da | te signed | (Month, Da | y, Year) |
| • | 1 | - | | 10/ | | | | [8 | 3206 | 3 | 0 | 2, | 08 | 12008 |
| | 5 | | 30 | Name and address of person who co | VIC. DI | 23a) (Type | e, Print) | | | | | | | |
| | | | 21 | Date filed (Month, Day, Year) | Tlace Bal | | re, 1 | ND | 2120 | 16 | | | | |
| | Stat Registra | | اد | rep 2 0 2008 | 32. Registrar's Signa | Sept. | 2 | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** MILDRED WILL 13,2008 February 2:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Woods White Marsh Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2√ F 87 Director 233-28-1210 <u> April 14,1920 West Virginia</u> Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2√ No Director Md. Baltimore Nottingham filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 8605 Sherington Rd. 21236 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White þ 3√Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: if item 27 is marked other ths any injury or other traumatic event, the angles. the 0 <u>Salesperson</u> Woolsworth Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Smith Annie Hall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Willis - son 8605 Sherington Rd. Nottingham, Md. 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Dulaney Valley Gdns. Feb. 16, 2008 Timonium, Md. 21. Signature of Eyneral Service Licenses 22. Name and Address of Facility 9705 Belair Rd. Schimunek's Funeral Home, Inc. Balto., Md. 21236 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician EMENTA 3 Mounts /Medical Due to (or as a consequence of): Examiner 3 Months KINGOWEW Sequentially list conditions, for a sequentially list conditions, for a sequential cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the death certificate be executed MAMON 1 DAU and burial-tra Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2 No the detached 9□Unknown 9 Unknown ģ signed d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Untrown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2 autopsy certificate 2 1 Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 N Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) MO 30. Name and address of person who completed cause of death (item 23a) (Type, Print) N. EUPW IONY MARCHITESE 31. Date filed (Month, Day, Year) egistrar's Signature State FEB 2 0 2008 Registra

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05080 State of Maryland / Department of Health and Mental Hygiene 2 11 11 12 1- For State Registrar Amend 29d, perMD, g876, 2/20/08 TTCertificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** $03:24p^{M}$ SIDNEY WATTERS JR. FEB. 14 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner TOWSON BALTIMORE GILCHRIST CENTER 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/23/1917 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. MARYLAND 217-26-1665 90 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE MONKTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code e filed within 72 hours after death with all Hygiene. USA 15157 MANOR RD. 21111 Funeral 14 Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: WHITE Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) HORSE TRAINOR HORSE TRAINOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked oth r other traumatic even SIDNEY WATTERS SR. MARY LOUISE PEARCE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LINDA (NONI) WATTERS(DAUGHT.) 15157 MANOR RD MONKTON, MD. 21111. Pages 1 and 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GREEN MOUNT CREMATORY 02/18/08 BALTO CITY, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility HENRY W. JENK 16924 YORK RD 21. Signature of Funeral Service Licenses W. JENKINS & SONS CO. YORK RD MONKTON, MD. 21111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final espiratos Physician das disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner neumon Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed mentia burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medical use as the l signed by the attending I IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 No After this certificate Division or Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.

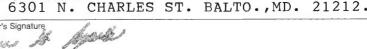
To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

WILLIAM McCONNELL M.D.





| \$ | | 1 - State Registrar 1. Decedent's Name (First, Middle, Last) | | • | • | tificate of | | , | Reg. No 2 | 0.8 | 0508 |
|--|----------------|---|---|--------------------|------------------------------|--|--|------------------------------------|-----------------|----------------|--|
| Physici | | Arlene Marie M | Walker | | | | | Month Februa | Day | Year | 3:40 P M |
| /Medio Examir | | 4a. Facility Name (If not institution, give s | | | | 4b. City, Town, or | r Location of Death | r corua | - | y of Death | 31101 |
| | | 221 South Eaton St | | | | Baltimo | | | | | |
| Funeral | | 5. Social Security Number 6. Sex 1 □ | M 2 → F | (In yrs. last birt | hday) rs. | Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Bir (Month, Da | | | olace (State or Foreigr ntry) |
| Director | | Usual Residence of Decedent | A | 60 | | | | Aug. 4 | 1947 | Cali | fornia |
| ryland how | | 10a. State 10b. County | | 10c. City, Town | | | | | | 1 | 10d. Inside City Limits |
| e Ma Ba-f s | Director | Tennessee Washing | ton | Jonesl | oro | ough | | | | | 1 □ Yes 2 No |
| vith th | Dire | 10e. Street and Number | | | | 10f. Zip Code | | | 10g. Citizen of | What Cour | ntry? |
| eath v | Funeral | 807 Bayless Road | <u>d</u> 2. Was Decedent Ev | ver in IIS | 13 W | 37659 | isnanic Origin? (Sn | ecity Ves or No | USA | ce - Americ | can Indian |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | b | 1 □ Never Married 2□ Married 3 □ Widowed 4 □ Divorced | Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | | Yes, specify Cuba ☐ Yes 2½ No | ispanic Origin? (Sp an, Mexican, Puerto Specify: | Rican, etc.) | Spec. | ack, White, | |
| hin 72 houe. e. an "natura Medical E | Completed | 15. Decedent's Educ (Specify only highest grade | ation completed) College (1-4or 5+ | | Decede (Give k life. D | ent's Usual Occup ind of work done o O NOT use retired | ation during most of work t) | ing | 16b. Kind of I | | |
| ed wit | Con | 12 | | · | nema | ker | | | | Home | |
| be filk tal Hy d oth event | Be | 17. Father's Name (First, Middle, Last) | _ | | | | 18. Mother's Name | | | • | |
| 2 should and Men is marke aumatic | 2 | Alwyn Kingston Dar 19a. Informant's Name/Relationship (Typ | | 106 | M-00- | . Add (044 | Shirley | | | | |
| th an | | Glenn Walker / Hus | , | I . | | | and Number or Rur | | - | | * |
| s 1 and f Health ftem 27 other tr | | 20a. Method of Disposition | | | | ition (Name of atory or other place | • | Date | 20c. Location | | |
| Pages nent of I int: If Ite | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Dination 5 ☐ Other (Specify) | enfoval from State | | | | Corp. 2-1 | 9-08 | Towson | , Mar | yland |
| permit. Departm Importa any in[u | | 21. Signature of Funeral Service Ligense | er / | . / | | | ss of Facility Ineral Ho | | | <u>•</u> | |
| 20 E # 9 | | 23a. Pirti. Enter the sease, or complice snock, or heart failure. List only on | eations that caused the cause on each line | | ot ente | 317 Cokes r the mode of dyin | sbury Roading, such as cardiac | d, Abin | gdon, M | aryl <u>a</u> | nd 21009 Approximate Interval Between Onset and Death |
| Physician | | Immediate Cause (Final disease or condition resulting in death) | Invasiv | E FUN | 6AL | L INFO | ECTION | | | | 3 months |
| /Medical Examiner | | resulting in death) | / | consequence o | f): | . / | 15-5-440 | | | | 9months |
| | ē | Sequentially list conditions, if any, leading to immediate | Due to (ur as a | consequence of | | 4 LEV | KENGA | | | | _/months |
| executed and al-transit | Examiner | Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last b. Due to (or as a consequence of). | | | | | | | | | |
| rificate be executed g physician and as the burial-transit | Medical B | d | | | | | | | | | |
| or the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The fune Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | Sc. If yes, outcome portion 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown | Fetal death | | Ectopic pregnancy Other <i>(specify)</i> | 1 | | | ate of delive | ery Day Year |
| s that | | Part II. Other significant conditions con- | tributing to death but | not resulting in | the und | derlying cause give | en in Part I. | 23e. Did 1 | tobacco use cor | ntribute to ti | he cause of death? |
| quire; en sig uíd be | ed by | | | | | | | 1 🗆 | Yes 2 No | 3 ☐ Prob | bably 4 ∐Unknown |
| law re as bec 2 sho | Completed | | | | | | | 24a. Was | an 24b | . Were auto | opsy findings available impletion of cause of |
| The ate his page | Com | | | | | | | | ormed? | death? | 2 □ No |
| clan: ertific ector, | Be (| 25. Was case referred to medical examiner? | nanital: | | | | 26. Place of Deat | h (Check only o | one) | | Son's |
| Physi this c al dire | 2 | 1 ☐ Yes 2 ☐ No H | ospital: 1 ☐ Inpatient 28a. Date of Injury | | | | 4 □ Ivursing Ho | | | | y,Residence |
| dIng h. After funer | tion | Natural 5 Pending | (Month, Day | | jury | 28c. Injun Work | y at k? Yes 2 □ No | 260. Describe | how injury occu | irrea | |
| or Atten after deat Director | Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Factory, office building, etc. (Specify) | | | | | | | | ber or Rura | al Route Number, |
| To the Hospital or Attend within 24 hours after death. To the Funeral Director; a completely filled in by the f | Medical C | 29a. Certifier (Check only one) 2 Medical Examin | ician: To the best of er: On the basis of a and manner state | examination and | death | occurred at the tire estigation, in my o | ne, date and place, pinion, death occur | and due to the red at the time, | cause(s) and n | nanner as s | tated. o the cause(s) |
| To the within To the comp | Me | 29b. Signature and title of certifier | | medica onco | | 29c. License | e number | | 29d. Date sign | / | |
| | | Michaeler th | ffind M | D Fe | low | DEA - | AJ4147 | 357 | 02/1 | 8/20 | 208 |
| 12 | | 30. Name and address of person who cor | | | | | INIA 401 | NOODA | NWAY A | AlTrais | DE MA 7172 |

DHMH 17 Rev 1/2001

State

Registrar

FEB 2 0 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1:45 P M February 16, 2008 Helen Spahr Walker /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Upper Chesapeake Medical Center Harford Bel Air Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 □ M 2 K F 168-14-1560 86 Apr. 27, 1921 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County show r 28a-f show notified at 1 □Yes 2X No Director Harford Bel Air Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or Items 23a or 128 West Ring Factory Rd. Rm. 1122 21014 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 TM Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be fille.
Department of Health and Mental Hygi Important; if item 27 is marked any injury or other any injury or other. is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Cleveland Spahr Mary Ellen Eyster 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John R. Walker / Husband 128 West Ring Factory Rd., Rm. 1122, Bel Air, MD21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Creme 3 Removal from State 4 □ Domation 5 □ (byther (Specify) Air Memorial Gdn: 2-19-08 Bel Air, Maryland 21. Signature of Funera Service McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 and . Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CARdioVasQUIGR Atheroscierotic **Physician** ten years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) burial-trar Due to (or as a consequence of) Box 68760. physician Physician/Medical attending p 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Maunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No certificate ! 1□ Yes 2 No 1 ☐ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attend within 24 hours arer death To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide

Registrar DHMH 17 Rev 1/2001

State

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

20

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NORT

Medical

M000055042

1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

BEL AIR MARYLAND 21014

FebruARY 16,2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] 05083 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 9:30 P. M Anne Marie Walsh February 17 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death N/A Baltimore Grace Lodge 8. Date of Birth (Month Pay Year) 03/03/1919 Birthplace (State or Foreign Country) Ohio If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Days Months Hours 1 ☐ M 2 1 F 88 Yrs. 578 20 2262 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Maryland Anne Arundel Baltimore 10g. Citizen of What Country? 10e. Street and Number U.S.A. 4126 Doris Avenue 21225 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Librarian Social Security Adm. 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) James Walsh Anna Hyland 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elmer Seidel 4124 Doris Avenue Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Cross Cemetery 02/21/2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gonce Funeral Service, P.A.

4001 Ritchie Highway Baltimore, Maryland 21225 21. Signature of Puneral Service Licer 4001 Ritchie Highway 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Accident ercbrou ascular disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequance of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. gartrointeting 1 Yes 2 No 3 Probably 4 ₽briknown deneutra 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2□ No 1□ Yes 2□No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 DNatural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

Examiner or Attending Physician: The law requires that the death certificate be executed tor use as the burial-transit Box 68760, P.0. Division of Vital Records, this certificate has After this certifice funeral director, p within 24 hours etter death.

To the Funeral Director: Af
completely filled in by the fu

by Physician/Medical Examiner

Physician

/Medical

Examiner

Funeral Directo

þ

Completed

Be

Funeral

Director

with the Maryland

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Importent: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, it is Madical Examinar must be politised at once.

Physician

/Medical

Baltimore, Maryland 21215-0036

Completed Be Certification: To Medicai

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

10

the Hospital

State Registrar

Hireal ! recourse Name and address of person who completed cause of death (Item 23a) (Type, Print)

lew aust MD

huses #508 Cleu Buring 7310 Ritchie 184 32. Registrar's Signature

1 Sertifying Physician: To the best of my knowledge, death pround at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D19667

29d. Date signed (Month, Day, Year)

02-19-2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Feb. 18, 2008 2:00 P Monica M. Yurkanin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1507 Sapphire Ct. Odenton Anne Arundel If Under 1 Year | If Under 24 Hrs.
Months | Davs | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Days 1 □ M 2 🕏 F Director 03-30-1931 Pennsylvania 187-24-9108 76 Usual Residence of Decedent 10c. City. Town or Location 10d, Inside City Limits 10a, State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 TNo Director MD Anne Arundel <u>Odenton</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? <u>United States</u> 1507 Sapphire Ct 21113 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ma any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Frank Namiotka Mary Snarski 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Ann Smith / Daughter</u> 2372 Sandy Walk Way Odenton, Maryland 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-20-2008 Arundel Crematory Odenton, Maryland 22. Name and Address of Facility of Funeral Service License Donaldson Funeral Home & Crematory 1411 Annapolis Road Odenton, Mary Rat1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician years Primary Pulmonary Hypertension /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the death certificate be executed aftending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 No Ö 9 ☐ Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown Sjogren's Syndrome Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Hypertension autopsy performed 1☐ Yes 2K No **Director:** After this certific I in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 【 Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: I or Attending Fafter death. 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

within 24 hours a

To the Funeral C To the Hospital

Medical

Erika Larson, MD 1132 Annapolis Road Odenton, Maryland 21113 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

29b. Signature and title of pertification

Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0053393

29d. Date signed (Month, Day, Year)

2/19/2008

| | | | for State Registrar | ate of Maryland | • | tificate of L | | | Jiene teg. NoΩ ∩ ∩ (| 05005 |
|-------------------|--|----------------|--|--|-----------------------|--|------------------------------|-----------------------|--|---|
| | 1112 | | Decedent's Name (First, Middle, Last) | | | | | Date of Dea Month | / 1111 | 3. Time of Death |
| П | Physicia /Medic | | WINFRED CARL YOUN | IG JR. | | | | | RY 16, 200 | |
| | Examin | er | 4a. Facility Name (If not institution, give stree | t and number) | | 4b. City, Town, or | | | 4c. County of De | |
| | Funeral | - | 2229 Ady Road 5. Social Security Number 6. Sex | 7. Age (In yrs. la | st birthday) | Forest If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. E | Birthplace (State or Foreign |
| | Director | | 226-38-5173 ^{1⊠ M} | ^{2□ F} 77 | 7 Yrs. | Months Days | Hours Min. | (Month, Day Feb. 9 | , 1931 Vi | country) rginia |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, | Town or Lo | cation | | | | 10d. Inside City Limits |
| | Maryl I-f sho fied a | tor | Maryland Harford | Fore | est Hi | 11 | | | | 1 □Yes 2 XNo |
| | th the or 28a e noti | Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of What | Country? |
| | ath wi | | 2229 Ady Road | | 10.1 | 21050 | | :6: \/ \/- | USA | merican Indian, |
| | ter de Items iner n | Funeral | 1 | Nas Decedent Ever in U.S Armed Forces? I X 1Yes 2 □ No | . 13. V | Was Decedent of Hi f Yes, specify Cuba | n, Mexican, Puerto | Rican, etc.) | Black, W | |
| 21215-0036 | s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Menhal Hygene. I Health and Saa or 28a-f show ithen 27 Is marked other than "ratural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | þ | 3 ☑ Widowed 4 ☐ Divorced | I X IYes 2 No fYes, Give ∕ear or Dates: | 1 | ∐Yes 2∐ xt o | Specify: | | Specify: | White |
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| 121 | within fene. than " | dmc | Elementary/Secondary (0-12) | College (1-4or 5+) | | al Manage | | | Telecomm | unication |
| d 2 | ifiled Hygi other rent, ti | Be C | 17. Father's Name (First, Middle, Last) | | 001101 | | | e (First, Middle, | Maiden Surname) | |
| /lar | should be ind Mental smarked o | To E | Winfred Carl Young | ſ | | | | _ | e Wilson | |
| Maryland | 12 sho | | 19a. Informant's Name/Relationship (Type. I | | | • | | | er, City or Town, State | e, Zip Code) |
| | 1 and Health Iem 27 other tr | | Donna Harris / Daug 20a. Method of Disposition | ghter 20b. Piz | 2229 ace of Dispo | Ady Road, sition (Name of natory or other plac | Forest | Hill, M Date | D 21050 20c. Location - City | or Town, State |
| E O | o = 136 | | 1 □ Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify) | ovar from State | | 1 Mem. Pa | 1 | _00 | Baltimore | e, Maryland |
| Baltimore, | permit. Page Departmen Important: any Injury once. | | 21. Signature of Funeral Service Licensee | / | Y 111 | Name and Address | Meral Ho | me, P.A | • | 7 |
| | 97 = 29 | | Stephen al Ne | igy | | | | | | 7land 21009 Approximate |
| | | | 23a. Part 1. Ent of the disease, or complication shock, or heart failure. List only one commediate Cause (Final | au x on each line. | Do not ent | er the mode of dyin | g, such as cardiac | or respiratory ar | Descri | Interval Between Onset and Death |
| | Physician /Medical | | disease or condition resulting in death) | Due to (or as a conseque | ence of): | 45 Wac | five Yu | May | Viscase | 15 years |
| 8 | Examiner | | Sequentially list conditions b. | | , | | | | | |
| 7 | pe sit | iner | Sequentially list conditions, if any, leading to immediate cause. Lifer underlying Cause (Disease or injury that initiated events c | Due to (or as a conseque | ence of): | | | | | 31 |
| /_ | be executed sician and burial-transit | Examiner | that initiated events c resulting in death) Last | Due to (or as a conseque | ence of): | | | | | |
| 68760, | ficate be executed physician and s the burial-transit | edical E | d | | | | | | | |
| _ | | Medi | IF FEMALE: | - | | | | | | |
| Вох | death certifi e attending id for use as | ian/ | 23b. Was decedent pregnant in the past 12 months? | If yes, outcome pf pregnan 1 □Live birth 2 □ Fetal • 4 □Pregnant at time of de | death 3□ | Ectopic pregnancy Other (specify) | • | | 23d. Date of Month | delivery Day Year |
| o. | 0 0 0 | Physician/M | | 9□Unknown | all 5 | | | | | |
| S, D | The law requires that the te has been signed by the hage 2 should be detache | by Pł | Part II. 7th r significant conditions contrib | uting to death but not resul | ting in the u | nderlying cause give | en in Part I. | 23e. Did to | | e to the cause of death? |
| ord | w require been sig should b | ted t | - Hyperchilester | 1emja | | | | 192 | Yes 2□No 3□ | Probably 4 Unknown |
| 3ec | has be | Completed | | | | | | 24a. Was autop | an 24b. Were psy prior rmed2 deatl | e autopsy findings available to completion of cause of h? |
| la | | | 25. Was case referred to medical | | | | 26. Place of Deat | 1□ Yes | 2 No 1 1 | |
| or Vital Records, | Physician: this certific ral director, | To Be | examiner? 1 Yes 2 No Hosp | oital: 1 ☐ Inpatient 2 ☐ E | R/Outpatier | nt 3 DOA Othe | | 11 | dence 6 □Other (5 | Specify) |
| n o | ding Ph .r After th funeral | | 27. Manner of Path 1X Natural 5 □ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time o Injury | Worl | k? | 28d. Describe I | now injury occurred | |
| Division | Attending r death. ector: After by the funer | icati | 2 Accident investigation 3 Suicide 6 Could not be | ≳8e. Place of injury - At hor | ne. farm. str | | Yes 2 □ No | 28f. Location (5 | Street and Number o | r Rural Route Number, |
| Div | after of Direct of in by | Certification: | 4 ☐ Homicide determined | building, etc. (Specify) |) | , , , | | City or Tov | vn, State) | , |
| | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f | | | an: To the best of my know On the basis of examinati | | | | | | |
| | thin 24 the F the F mplete | Medical | 290. Signature and the of certifier | and manner stated. | | 29c. Licens | | | 29d. Date signed (M | |
| \ | T will | | 171) | FACP. | | 143 | 9077 | 7 | L. 611 | 18 7008 |
| ,, | 1x1 | 1 | 30 Norme and address of person who comp | leted cause of death (Item | 23a) (Type, | Print) | 11 1/ | | 11/4 | , 1- 0002 |
| |) _, | | | 0 13083 | usness | (even) | by to | and 1 | MD 210 | 40 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) FEB 2 0 2008 | 32. Registrar's Signat | ure | 68 | | | | |

DHMH 17 Rev 1/2001

Winfred Carl Young

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 17, 2008 5:45 A. [™] MABEL-MARY ZIMMERMAN February /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Stella Maris Timonium Baltimore | Funder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. July 2, 1 9. Birthplace (State or Foreign Country) Maryland Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F 215-10-6262 92 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Lutherville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3 Nightingale Way 21093 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: ģ White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Medical year 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) Be Edith Hanna Brunt Armin Jaeger, Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher E. Zimmerman (son) 3 Nightingale Way A5 Lutherville, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 2-20-08 Pikesville, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death 1135001 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or seconsequence of): Bureselevesi **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Division or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours a 1 > ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) C 8

Registrar
DHMH 17 Rev 1/2001

5:45

ZIMMERMAN

MABEL

2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

EDDIE NAKHUDA, M.D.

FEB 2 0 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar amend #10c&19b Per FH G876 2d2Nifl@atJUf Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2100 PM **Physician** 02 /Medical Lester Kenneth Zick 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Square Hospital

5. Social Security Number 6. Sex 7. Baltimore Tordale Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F Director 89 01/16/1919 Maryland 218-03-8382 Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 1 ☐ Yes 2X No Director MD Baltimore Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or Elinore Elimore U.S.A. or Items 23a must Avenue 21206 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status "natural", or Item edical Examiner r Black, White, etc. 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "I amy Injury or other traumatic event, the Meaonce. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Postal Service Postal Supervisor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 George Zick Catherine Merritt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6306 Elimore Avenue - Baltimore, Maryland 21206 Terry L. Zick (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State 02/20/2008 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Cem. 22. Name and Address of Facility E.F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee 6 11750 Belair Road - Kingsville, Maryland 21087 assakn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician DOXE mic /Medical Due to (or 1 a consequence of): Examiner tancreatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be execute use as the burial-tran and Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy atter for u Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 performe 2 - No After this certification funeral director, I 25. Was case referred to medical 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Anatural 5 Pending 1 ☐ Yes 2 ☐ No dea h. investigation To the Hospital or Attendi within 24 hours are read hor To the Funeral Director 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

Dr. Jose Ohin 31. Date filed (Month, Day, Year) FEB 2 0

(Check only

29b. Signature and title of certifier

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Usine, MD

RES0000

29c. License number

29d. Date signed (Month, Day, Year)

altimore.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 710 **Physician** 2008 FEDTHARY John Lawrence Zacharski /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give stree **Examiner** If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 □ F Director 03.11.1943 MD with the Maryland 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 10 Director <u>Baltimore</u> MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 U.S.A. 308 Mace Avenue Apt. B Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filled within 72 hours after or and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White Specify: ģ 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ouebecor Printer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fount of Health and Mental I int: If item 27 Is marked or Edward Wescott Genevieve Zacharski injury or other traumatic ం 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, MD 21221
20c. Location - City or Town, State nd 308 Mace Avenue Apt B

20b. Place of Disposition (Name of cemetery, crematory or other place) Kathaleen Hensley/friend permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02.18.08 Beltsville, MD Chesapeake Crem. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility CAFA/Stephen D. LohrmannPA 21. Signature of Funeral Service Licensee Green Pastures Dr. Balto.. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a conse uence of): **Physician** 30 /Medical **Examiner** Coronary Sequentially list conditions, if any, bearing to increase cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Oue to (or as a nonsequence of) Examiner The law requires that the death certificate be executed physician and Division or Vital Records, P.O. Box 68760, Due to (or as a consequence of) Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by ti 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? certificate has autonsy performe med? 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. ER/Outpatient 3 DOA 1 Ves 2 No Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Itam 23a) (Type Print)

1) anil Hawlard M. 1. 821 N Futaw St. Sure 405 Bactimere, Md 2120/

Registrar

State

31. Date filed (Month, Day,

32. Redstrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

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gistrar's Signature

| | | | State of Maryland / Department of Health and Months 1 - State Registrar | | ene 2 (| 008 | 05090 |
|------------|--|----------------|--|--------------------------------------|--------------------------|---|---|
| | 77.4 | | | 2. Date of Death | | 4 | 3. Time of Death |
| | Physicia | | Mohammad M. Alem | Month February 4 | Day 2008 | Year | ':45 A M |
| | /Medic | 100 | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death | | 4c. County | y of Death | |
| | Examin | - | | | Monto | omery | |
| - 17 | - 1771 - I | | ++00 Habe Nebe Highway, #iles | 8. Date of Birth | | | e (State or Foreign |
| | Funeral Director | | 1 1 M 2 □ F Vrs Months Days Hours Min. | (Month, Day, 'March 21, | | Country Iran |) . |
| | The man | | Usual Residence of Decedent | march 219 | 1727 | Han | |
| | land ow | | 10a. State 10b. County 10c. City, Town or Location | | | 10d | Inside City Limits |
| | Mary f sh | 호 | Maryland Montgomery Bethesda | | | | 1 ☐ Yes 2 No |
| | the 28a notif | Directo | 10e. Street and Number 10f. Zip Code | 10 | g. Citizen of | What Country | ? |
| | with Sa or t be | | 4400 East West Highway, #1107 20814 | | nited S | tates | |
| | eath | era | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Medican) (Speci | | | ce - American | Indian, |
| _ | 72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dieal Examiner must be notified at | Funeral | 1 Never Married 2 N Married 1 Yes 2 N No | Rican, etc.) | Bla | ick, White, etc | :. |
| 215-0036 | Irs at | þ | If Yes, Give 1 ☐ Yes 2 ☒ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: | | Specia | <i>fy:</i> Whi | te |
| ş | 2 hou attura | ed | 15. Decedent's Education 16a. Decedent's Usual Occupation | | 6b. Kind of E | Business/Indus | stry |
| : : | ılın 7% n "n Medi | Completed | (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) | ng | | | |
| | with jiene | E O | 4 Engineer | | Text | ile | |
| 0 | Hyg othe | BeC | 17. Father's Name (First, Middle, Last) 18. Mother's Name | (First, Middle, M | laiden Surna | me) | |
| Maryland 2 | is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | To B | Mohammad Hossein Alenzadeh Mariam Bei | be Baghon | ı | | |
| 2 | shound M | | 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rura | l Route Number, | City or Town | , State, Zip C | ode) |
| Ĕ | nd 2 Ulth a 27 is r trau | | Laleh Alemzadeh, daughter 11016 Gainsborough Road, Pote | omac, MD | 20854 | | |
| Baltimore, | Hea Hea tem othe | | , | ate 2 | Oc. Location | - City or Towr | n, State |
| <u>Ö</u> | | | 1 \(\Delta \) Burial 2 \(\text{Cremation} \) 3 \(\text{Removal from State} \) 4 \(\text{Donation} \) 5 \(\text{Other} \) (Specify) \(\text{Park lawn Memorial Park} \) Feb. 6, | 2008 R | ockvill | e, Maryl | and_ |
| ≣ | artme | | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hine | | | | |
| g | permit. Page Department of Important: If any injury or once. | , J | 1180 | 00 New Ham | pshire . | Avenue | |
| | | | 23a. (Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o | rer Spring r respiratory arre | | A | pproximate |
| | | | Shock, or heart failure. List only one cause on each line. | | | | iterval Between Inset and Death |
| E | Physician | | disease or condition CARDIOPULMONARY ARREST | | | M | INUTES |
| | /Medical Examiner | | Due to (or as a consequence of): | | | 77 | TADC |
| | b | <u>.</u> | Sequentially list conditions, if any leading to immediate b. CORONARY ARTERY DISEASE Due to (or as a consequence of): | | | Y | EARS |
| | sit ed | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | | |
| | ecut and -tran | хап | that initiated events c. resulting in death) Last Due to (or as a consequence of): | | | | |
| 8760, | The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | | | | | - | |
| | cate physi the b | dical | U | | | | |
| × | ertific | /Me | IF FEMALE: 23c. If yes, outcome pf pregnancy | | 004 5 | -1 | |
| Box | leath certific attending p I for use as | Physician/Me | 230. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy | | | ate of delivery Nonth D | ay Year |
| | at the de by the a rtached f | /sic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown | | | | |
| л О | d by | Ρh) | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did tob | acco use coi | ntribute to the | cause of death? |
| ŝ | res tha signed l | by | Tattir. Other algumean commons commons to today but not recurring in the discorping scales given in tatti | 1□ Ye | s 2🖔 No | 3□ Probal | oly 4 □Unknown |
| Records, | w require been si should b | ted | | | | | |
| Ö | law as b | Completed | | 24a. Was ar autops | n 24b | Were autops prior to comp | y findings available pletion of cause of |
| | | νo | | perform 1 Yes 2 | nea? ≧ | death? 1 ☐ Yes 2 | □No |
| Vita | slan: ertific ctor, | Be (| 25. Was case referred to medical examiner? | Check onl one | 9 | | |
| | Physic this ce al dire | 2 | | me 5 🔀 Reside | nce 6 □O | ther (Specify) | |
| ر ا | ding Ph n. After th funeral | Ë | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 4 | 28d. Describe ho | w injury occu | urred | |
| Division | arti. or: Ai | atic | 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No | | | | |
| N S | or Attended the death of the color of the co | III | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Str City or Town | reet and Nun , State) | nber or Rural | Route Number, |
| 5 | s after | Certification: | | | | | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral cirector, After this certific completely filled in by the funeral director, I | | 29a. Certifier (Check only (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and the content of the basis of examination and the content of the con | and due to the cared at the time. de | ause(s) and r | manner as sta | ted. he cause(s) |
| | the H in 24 he Fi plete | Medical | one) and manner stated | | | | |
| | To t With To t | Σ | 29b. Signature and title of certifier 29c. License number | 29 | 9d. Date sign | ned (Month, D | ay, Year) |
| | 10 | | D60887 | FI | EBRUARY | 5, 2008 | |
| | Ψ | | 30. Name and address of person who completed vuse of death (Item 23a) (Type, Print) | | - | | |
| | | | JACK L. FLYER, M.D., 5530 WISCONSIN AVENUE, #750 CHEVY CHASE, MAR | YLAND 208 | 315 | | |
| | Sta | | 31. Date filed (Month, Day, Year) Registrar's Signature | | | | |
| | Regist | ar | FEB 0 6 2008 June 15 Aprile | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 **Physician** ANDERSON, SR. 540 M +RTHUR /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 3637 Patuxent River Rd. Davidsonville Anne Arundel 6. Sex 10 M 2 ☐ F If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6/19/1923 Birthplace (State or Foreign Country) **Funeral** Hours Months Days Director 212-20-1769 84 Marvland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 ☐No Director Maryland Davidsonville Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3637 Patuxent River Rd. 21035 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 ☐ No If Yes, Give Year or Dates: 1943–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black White etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🕅 No White Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Carpenter Union permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If Item 27 Is marked other in any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Lee Anderson Elsie Randall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean H. Anderson/ Wife 3637 Patuxent River Rd., Davidsonville, MD 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Cemetery 2/7/08 21. Signatur of 5 news the Licensee 4 ☐ Donation 5 ☐ Other (Specify) Davidsonville, MD 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition eloma mon **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if the line immediates a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of Examine burial-tran Due to (or as a consequence of) Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy jo in the past 12 months? 1☐ Yes 2☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þe 2MNo 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1□ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 🔲 Inpatient ျှ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

with the Maryland

death v

within 72 hours after

Baltimore, Maryland 21215-0036

certificate be executed and attending physician ed by the detached has certificate within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir To the Hospital or Attending

🕽 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DEFENSE HIGHWAY ANNAPOLISMO 21401 KHAEZ JAM M

State Registrar

Medical

29b. Signature and title of certifier

29a. Certifier

31. Date filed (Month, Day, Year) FEB 0 5 2008

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05092 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 1214 AM JIMENEZ-2008 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Harwood Mandrin Hospice House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March I, 1955 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, Days Hours New York 1 🗌 M 52 060-48-6826 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2☐No Annapolis Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21402 4 South Monroe Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes **XX**No If Yes, Giv& Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married White Specify: Puerto Rican 1X Yes 2□ No 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Social Security Bi-Lingual TSA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Velazquez Eva Jimenez Carmelo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1625 NW 2nd Ave Fort Lauderdale FL.33311 Herbert Alvarez Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/2/08 Baltimore, MD Metro Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer P.A. Hardesty Funeral Home P.A. 12 Ridgely Ave, Annapolis, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 months

Physician /Medical **Examiner**

Physician

/Medical

Director

Funeral

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any fully or other traumatic event, the Medical Examiner must be profit one.

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

| resulting in death) | a. Due to (or as a consequence of): | 4 * 1 | | |
|---|--|--|--|--|
| | Due to (or as a connectuence of). | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b Due to (or as a consequence of): | | | |
| that initiated events 'resulting in death) Last | cDue to (or as a consequence of): | | | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12-months? 1 □ Yes 2 ☑ No 9 □ Unknown | | pic pregnancy er (specify) | | 23d. Date of delivery Month Day Year |
| Part II. Other significant conditions of | contributing to death but not resulting in the underly | ring cause given in Part I. | | use contribute to the cause of death? |
| | | | 24a. Was an autopsy performed? 1∐ Yes 2 ☑ N | 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No |
| 25. Was case referred to medical examiner? | | 26. Place of Death | | · |
| 1 Yes 2 No | Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 | ☐ DOA Other: 4 ☐ Nursing Hor | ne 5 🗆 Residence | 6 Dother (Specify) Noscella |
| 27. Manner of Death Natural 5 Pending Accident investigation | | Work? | 28d. Describe how inju | ury occurred |
| 3 Suicide 6 Could not b 4 Homicide determined | | actory, office | 28f. Location (Street a City or Town, Sta | and Number or Rural Route Number, te) |
| 29a. Certifier (Check only one) 1 Certifying Pl | hysician: To the best of my knowledge, death occ miner: On the basis of examination and/or investig and manner stated. | urred at the time, date and place, gation, in my opinion, death occurr | and due to the cause(ed at the time, date a | s) and manner as stated. nd place, and due to the cause(s) |
| 29b. Signature and title of certifier | | 29c. License number | 29d. D | ate signed (Month, Day, Year) |

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Registrar

31. Date filed (Month, Day, Year) FEB 0 5 2008

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cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 05093 State of Maryland / Department of Health and Mental Hygiene 2 1 3 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician Ruth N. Andrews 3:00 P M Febuary 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 XF Months Days Hours 214-30-0302 102 Director Jan. 14, 1906 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10h County 10d Inside City Limits iral", or items 23a or 28a-f show Exa⊞lner must be notified at 1 ☐ Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6000 Hansen Circle U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. of fled within 72 hours after of Hygiene.

If Hygiene.

Other than "natural", or iter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Mamied Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No ð Specify: White 3 X Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Laboratory Technician U.S. Government or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) l and 2 should be fil lealth and Mental H m 27 Is marked oth Be August Langlotz Julia Elizabeth Dean ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is any Injury or other trainonce. 6000 Hansen Circle, Clyde Andrews - Son Frederick, Maryland 21702 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State Clarksburg Cemetery 02/07/07 5 Other (Specify) Clarksburg, Maryland 22 Name and Address of Facility Molesworth-Williams P.A., Funeral Home 21. Signature of Funeral Service Licensee 26401 Ridge Road, Damascus, Maryland 20872 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final dso **Physician** disease or condition resulting in death) hum is /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 1 ☐ Yes 2 ☐ MO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an has page 2 autopsy performed? certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 은 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospital 1-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

31. Date filed (Month, Day, State FEB 08 2008 Registrar

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29b. Signature and title of certified

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and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year,

29c. License number

29d. Date signed (Month, Day, Year)

/Medical Examiner 68760 Box (o ۵. Records, Vital o Division

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Maryland 21215-0036

Baltimore,

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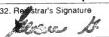
filled in by the funeral

State Registrar

29b. Signature and title of certifier redection ess of person who completed cause of death (Item 23a) (Type, Print) C. Huddleston, 106 Milford St., Salisbury, MD 21801

29a. Certifier

31. Date filed (Month, Day, Year) FEB 0 7 2008



Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

129105

29d. Date signed (Month, Day, Year)

February 7, 2008

State of Maryland / Department of Health and Mental Hygiene 2 🕦 🕦 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** ам William 5:20 Frederick Burnett January 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4426 Strathmore Avenue Garrett Park Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1⊠M 2□F Director 349-14-0895 87 Feb. 14, 1920 Illinois Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d, Inside City Limits 10b. County show r 28a-f sh notified 1X Yes 2 No Director Maryland Montgomery Garrett Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or "natural", or Items 23a 4426 Strathmore Avenue 20896 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant If Item 27 is marked other than "natural", or Ite ury or other traumatic event, the Mental at Examine ury or other traumatic event, the Mental at 1 X Yes 2 No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No þ 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Special Agent Fingerprint Division F.B.I. 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be P Fred G. Burnett Velma Stricklen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and:
Department of Health
Important: If Item 27
any Injury or other tra 542 Tawnyberry Lane, Collegeville, PA 19426 Anne Atlee / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 2/5/2008 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Simple Tribute Funeral and Cremation Center 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. En'er the / ise ise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ail ye. List only one ceuse on each line. Immediate Course (Final disease or condition resulting in death) Physician a Atherosclerotic Heart Disease Months /Medical Due to (or as a consequence of): **Examiner** Chronic Obstructive Pulmonary Disease Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exami burial-trar Due to (or as a consequence of): physician a the burial Division or Vital Records. P.O. Box 68760. Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Prostate Cancer 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No Multiorgan Failure 24a. Was an s certificate has the lirector, page 2 s autopsy performed? Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No after death.

Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 29a, Certifier 1 🛭 Certifying hysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 ☐ Medical E On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29c. License number 29b. Signature and fitle of certific 29d. Date signed (Month, Day, Year) D0066384 1/31/2008 20878 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

10810 Darnestown Road, #202 Gaithersburg, MD

Jimena Maria Gome⊌ Del Carpio M.D.

2008

31. Date filed (Month, Day, Year)

FEB 06

3 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 05096 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Pauline Jan. 31, 2008 Α. 7:30p M Bays /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kingshire Manor Assisted Living Rockville Montgomery If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 2 / 21 / 1 9 1 0 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 97 1 M 2 XF 228-40-9940 PA. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10h. County 10d Inside City Limits ms 23a or 28a-f show must be notifled at MD Montgomery Silver Spring 1 ☐ Yes 217 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9419 Russell Road 20910 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian or items 11. Marital Status ı "natural", or item: ledical Examiner m Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐XNo Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical College (1-4or 5+) 5 + Elementary/Secondary (0-12) Social Case Worker U.S.Soldiers Home 7 Is marked other traumatic event, the permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Simon Bays Elpitha Gianelli ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Comas/Nephew Thorburn Rd.Gaithersburg, Maryland 20878 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Fort Lincoln 5 Other (Specify) 2/08/2008 Brentwood, Md 4 Donation 21. Signatur Funeral Service PHYLTPADORTNALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Atheroscerotic Heart Disease /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown þ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed hypertension 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 anemia autopsy performe certificate congestive heart failure or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 MOther (Specify) assisted 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this s after death.

I Director: After this of in by the funeral of living 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours at To the Funeral Completely filled it To the Hospital filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28656 Feb.5,2008 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rayi Passi 15225 Shady Grove Rd M.D. Rockville, Md 20850 31. Date filed (Month, Day, Year) 329Registrar's Signature State FEB 06 2008 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

| J | 9.0 | | 0 | n | (3 | 0 | |
|-------|------|-----|---|---|----|---|--|
| | Reg. | No. | 4 | U | U | 0 | |

| a | Physician /Medical |
|-------|-----------------------|
| | Examiner |
| g -9% | Funeral |

Director Usual Residence of Decedent r 28a-f show notified at 10a State 10b. County 10c. City, Town or Location Director NEWBURG MARYLAND CHARLES 10f. Zip Code 10e Street and Number "natural", or Items 23a or dical Examiner must be 12620 SHILOH CHURCH ROAD 20664 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 10 t 1 □ Yes 2 X No Maryland 21215-0036 Specify þ 3 XWidowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation Medical 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
10TH GRADE College (1-4or 5+) FOOD SERVICE WORKER 1 and 2 should be filed wi Health and Mental Hygier em 27 is marked other th ther traumatic event, the 17. Father's Name (First, Middle, Last) Be JOHN WILLIAM BUTLER 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. PAMELA YATES / DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Star sture of Fundral Ser to Liounda July THORNTON FUNERAL HOME, P.A. LYDIA C. THORNION JOHNSON MO0583 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-trai Due to (or as a consequence of): Box 68760, physician death certificate be Physician/Medical the as IF FEMALE use 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 M No 4□Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown by signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 1 Yes Completed 24a. Was an page 2 s autonsy certificate 25. Was case refered to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2₩ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Mariner of Death 1 Natural funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical one) and manner stated. within 2 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAXMI BERWA, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008 FFB 07 DHMH 17 Rev 1/2001

2 Date of Death 1. Decedent's Name (First, Middle, Last) 7:20 P M FEBRUARY 2008 CATHERINE ARMINTA BUTLER BROWN 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) FORT WASHINGTON HEALTH & REHAB. CNTR PRINCE GEORGES FORT WASHINGTON 8. Date of Birth (Month, Day, Yea APRIL 26, If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Days Hours 1929 MARYLAND 577-40-0230 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? UNITED STATES 14. Bace - American Indian. Black, White, etc. Specify: BLACK 16b. Kind of Business/Industry EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) MARY AGNES BOND BUTLER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8050 WHEATLEY ROAD, LA PLATA, MARYLAND 20c. Location - City or Town, State MARYLAND VETERANS CEMETERY FEB. 12, 2008 CHELTENHAM, MARYLAND 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 prelle 23d. Date of delivery Month Day Year

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

7700 OLD BRANCH AVENUE, SUITE C101, CLINTON, MARYLAND

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| William David Di | | State 1- For State Registrar | e of Maryland / Depa <i>Cer</i> | tificate of De | | ntai riygie | Reg. | No. 201 | 08 0509 |
|--|-----------------|---|---|---|--|--------------------------------------|---------------------------------------|--|--|
| Physicia | n/ | Decedent's Name (First, Middle,L | ast) | | | | ite of Death | ay Year | 3. Time of Death |
| Medical Examir | _ | William | David | | rooks | | bruary 9, | | 1400 hrs |
| jir. | | 4a. Facility Name (if not institution, g | give street and number) | | ity, Town, or Location | n of Death | | 4c. County of Dea | |
| | | 13517 Tower Road | | | andywine | | C C C C C C C C C C C C C C C C C C C | Prince Georg | |
| Funeral Director | - 1 | 218-52-9233 1 | Sex 7. Age (In yrs. Ia | | Under 1 Year If Un onths Days Hou | ırs Min. | 6 / 08 / | MM/DD/YYYY) 9. E Fore | eign Maryland Country) |
| any | - | Usual Residence of Decedent 10a. State 10b. County | 10c City | Town or Location | | | | | 10d. Inside City Limits |
| \$ | | , | | | | | | | 1 X Yes 2 No |
| Maryland 28a-f show d at once. | 흥 | Maryland Princ | e George | | ndywine | | 110a | . Citizen of What Co | untry? |
| or 28 | jre | | _ | | • | | | | , |
| ith th | 딅 | 7315 Moore Ro | 12. Was Decedent Ever in U. | S 13 Was De | 20613 cedent of Hispanic O | rigin? (Specify | Yes or No. | USA 14 Race - Ame | erican Indian, Black, |
| illell | uneral Director | 1 Never Married 2 Marri | ed Armed Forces? | | pecify Cuban, Mexica | | | White, etc. | , |
| fler d F', or | ᄣᅵ | 3 Widowed 4 X Divorce | 1 Yes 2 No ed If Yes, Give Year 1 9 6 9 – 7 | 7 | 2 X No specif | fy: | | Specify: B1 | ack |
| ours a | g p | 15. Decedent's Education (Specify | only highest grade completed) | 16a. Decedent's U | sual Occupation (Giv | e kind of work d | one 1 | 6b. Kind of Busines | s/Industry |
| 72 hc | Completed | Elementary/Secondary (0-12) | College (1-4 or 5+) | during most c | f working life. DO NO | T use retired) | 1 | | |
| orthin ene. | E C | 12 | | Ele | ctrician | | | Self-E | mployed |
| 15-C | | 17. Father's Name (First, Middle, La | • | _ | | er's Name (First | , Middle, Ma | iden Surname) | |
| 121 d be 1 fental arket | ш. | Lewis 19a. Informant's Name/Relationship | | rooks | | nette | | | Hawkins |
| MD 21215-0036 td 2 should be filed within 7 tith and Mental Hygiene. In 27 is marked other than aumatic event, the Medica | -1 | | | | iress (Street and N | | | • | |
| and 2 ealth: | ŀ | Dean Brooks/ S 20a. Method of Disposition | | | (Name of cemetery, | PI. Wa | | Maryla 20c. Location - City | nd 20601 or Town, State |
| Ore Ses 1. Fof H | | 1 X Burial 2 Cremation | Removal from State | crematory or other p | lace) | | | • | , |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 33a or 28a-fsho injury or other traumatic event, the Medical Examiner must be notified at once. | - | 4 Donation 5 Other Spec 21/Signature of Funeral Service Lin | | ryland V | eterans | 2/21/ | 08 C | <u>Cheltenh</u> | am,Maryland |
| Ba perm Depa Impe | | | | 0.1 | and Address of Faci | "' Adams | Fun | eral Hon | ne PA |
| Physician | \dashv | 23a. Part I. Enter the disease, or co | mplications that caused the death | Do not enter the m | ode of dying, such as | cardiac or resp | iratory arres | SCO, Mary t, shock, or heart | Approximate Interval |
| /Medical | 4 | failure. List only one cause on Immediate Cause (Final disease | each line. a. Narcotic intoxica | tion | | | | | Between Onset and Death |
| xaminer | | or condition resulting in death) | Due to (or as a consequence o | | | | | | |
| | | Sequentially list conditions, | b | | | | | | |
| | <u>i</u> | if any, leading to immediate rause. Enter Underlying Cause | Due to (or as a consequence o | if): | | | | | |
| | Examiner | (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence o | of): | | | | | |
| ecuted and trans | | | d | | | | | | |
| .760, ficate be executed g physician and the burial - transit | Medical | X UNPENDED | #23a,PII,27,28a- | f. permE.g8 | 77 3/10/08 T | Т | | | |
| 760 ficate ficate fre b | ğ | IF FEMALE: 23b. Was decedent pregnant in the | 23c. If yes, outcome of preg | inancy | | | | 23d. Date of deliv | |
| r 68 certil | sician/ | past 12 months? | 1 Live birth 4 Pregnant at time of de | 2 Fetal d | eath 3Ecto (Sp <i>ecify</i>) | pic pregnancy | | Month | Day Year |
| Box death | ysi | 1 Yes 2 No 9 Unkno | wn 9 Unknown | o 🔛 Other | (Specify) | | | | *** |
| O at the d by t | y Phys | Part II. Other significant condition | s contributing to death but not r | esulting in the unde | lying cause given in | Part I. | | | to the cause of death? |
| ires the signe | g p | Post traumatic s | stress syndrome | | | | 1 Yes | 2 No 3 P | robably 4 Unknown |
| ords v requ | Completed | | | | | | 24a. Was an autopsy | | autopsy findings available o completion of cause of |
| ecc he lav ate ha | mo M | | | | | | perform ✓ Yes 2 | ed? death | |
| m: T m: T rrtific tor, p | ωl | 25. Was case referred to medical | | | 26.Place of Dea | | ne) | | |
| Division of Vital Records, P.O. tolor Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detach | To B | examiner? 1 ✓ Yes 2 No | Hospital: 1 Inpatient 2 | ER/Outpatient 3 | DOA Other | Nursing Hor | me 5 R | esidence 6 🗸 Ot | ner: Scene |
| ing Pl | ٳؾؘ | 27. Manner of Death | 28a. Date of Injury (Month, Day,Year) | 28b. Time of Injury | | i | Describe ho | w injury occurred | |
| ttend death. | atie | Natural 5 Pending 2 Accident Investig | | Fnd 1:52 p | n 1 Yes 2 | X No un | k | | |
| ivis lor A after Direc | Certification: | 3 Suicide 6 X Could n | | ome, farm, street, fa | ctory, office building, | | or Town, Sta | te) | Rural Route Number, City |
| spita hours neral | | 4 Homicide determine 29a. Certifier | (apreny) House | | | 135 | 1/ Towe | r Kd. Brand | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit | Medical | (Check only Certifying Phys | ician: To the best of my knowled ner:On the basis of examination a | ge, death occurred a and/or investigation, | at the time, date and in my opinion, death | place, and due to occurred at the | to the cause(time, date ar | s) and manner as s nd place, and due to | tated. the cause(s) |
| To To To Com | Med | 29b. Signature and title of certifier | and manner stated. | | 29c. License numb | | | 29d. Date signed (f | |
| | | Vous - A | o (Maile | | O.C.M.E. | | | February 10, 2 | |
| | - | 30. Name and address of person wh | o completed cause of death (Item | 1 23a) | l | | | | |
| B | | | Assistant Medical Examir | · | Street, Baltimo | re, MD 2120 |)1 | | |
| Sta | | 31. Date filed (Month, Day, Year) | 32. Registrar's Signatu | ure / | M. | | | | |
| Regist | rar | FEB 1 5 | 2008 Blown. | the Apan | | | | | |

| | | | 1 - For State Registrar | State of Marylan | | ent of Health and ate of Death | Mental Hygier | | 05099 |
|-------------|---|------------------|--|--|--|---|---|--|--|
| | Physic /Medi Examir | cal | 1. Decedent's Name (First, Middle, Last) Set + + 4a. Fecility Name (If not institution, give set) | Street | S | CKett ty, Town, or Location of Deat TUSBURI | Feb 3 | Day Year 2008 46 County of Death | 3. Time of Death U.30 a M |
| | Funeral Director | | Usual Residence of Decedent | M 200 81 | Yrs. Month | | Month, Day, Yea | 921 BIOX | place (State or Foreign htry) (OM, V-A |
| | the Maryla 28a-f ehov | rector | milifi | inn | alisbur | Y Zip Code | 100 (| Citizen of What Cou | 10d. Inside City Limits 11 Yes 2 □ No |
| | nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artinent of Health and Mental Hyglene. artinent of Health and Mental Hyglene. region: If item 27 is marked other than "natural", or itema 23a or 28a-f ehow origin: If item 27 is marked other than "natural", or itema 25a or 28a-f ehow injury or other traumatic event, the Medical Examinar must be notified at a figure or other traumatic. | Funeral Director | 710 Dennis | Street 2. Was Decedent Ever in U Armed Forces? | | 2 8 0 cedent of Hispanic Origin? (Specify Cuban, Mexican, Puer | pecify Yes or No- | 14. Race - Ameri Black, White, | States can Indian, |
| 21215-0036 | 2 hours after latural', or i | þ | 1 Never Married 2 Marned 3 Novidowed 4 Divorced 15. Decedent's Educ | 1 Yes 2 No If Yes, Give Year or Dates: | 16a, Decedent's U | 2 No Specify: | 16b. | Specify: Bi | ACK |
| N | filed within 7 Hygiene. pther than "n ent, the Medi | Completed | (Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) | College (1-4or 5+) | (Give kind of the life. DO NOT | work done during most of wo use retired) Pera | to R ne (First, Middle, Maid | Ser | vices |
| Maryland | should be find Mental Firmarked of | To Be | George W | . Have | - | Glad | 145 | W | 'hite |
| | 1 and 2 sho Heaith and Iom 27 is m | | 0 100 | ett (sen) | 710 Den | iss (Street and Number of Ri | Sbury, Me | d 2180 | 5/ |
| Baltimore, | ermit. Pages ' epartment of F nportant: If Its ny injury or of | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re 1 4 □ Donation 5 □ Other (Specify) | emoval from State | Place of Disposition (Nemetery, crematory of the City of the City of the contract of the city of the c | Nemifarka- | 9-08 50 | Location - City or To | y, md |
| Ba | ermit. epartm mports ny inju | | 21 Bignatos: A neral Service Lense | coll | - Beni | and Address of Facility The Smith WISabell | | al sbury | md 21801 |
| | Physician /Medical | | 23a. Part1. Enter perdisease, o complice shock, different later only on Immediate Causa (Final disease or condition resulting in death) | rations that caused the death e cause on each line. ATHERASCUS Due to (or as a consequ | -41TIC (| ode of dying, such as cardiac | | EASE | Approximate Interval Between Onset and Death |
| | ate be executed Support of the partial francial and the burial and the burial francial and the burial francial and the burial and the burial francial and the burial and the burial and the burial francial and the burial and the burial francial and the burial and the | cal Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence of the consequence of t | , | | | | |
| .O. Box 68 | The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | c. If yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de | death 3 Ectopic | | | 23d. Date of delive | ery Day Year |
| Hecords, P. | w requires that been signed b should be deta | by | Part II. Other significant conditions cont | ributing to death but not resu | ulting in the underlying | cause given in Part I. | 23e. Did tobacco | o use contribute to to | |
| | | Completed | 25. Was case referred to medical | | | | 24a. Was an autopsy performed? | prior to co death? | ppsy findings available impletion of cause of |
| or Vital | | To Be | examiner? | spital: 1 Inpatient 2 | ER/Outpatient 3 [| | ome Residence | 6 Other (Specif | (y) |
| _ | en en en | ation: | 27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how inj | | |
| DIVISION | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu | Certification; | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of Injury - At ho building, etc. (Specify | ") | | 28f. Location (Street a City or Town, Sta | a(e) | |
| : | To the Hospital or within 24 hours after to the Funeral Discompletely filled in | edical | 29a. Certifier 1 Certifying Physi (Check only one) 2 Medicel Examine | cien: To the best of my know er: On the basis of examinat and manner stated. | wiedge, death occurre ion and/or investigation | d at the time, date and place on, in my opinion, death occu | , and due to the cause(rred at the time, date a | s) and manner as s nd place, and due to | tated. o the cause(s) |
| 1 | vithi To tt | Ž | 29b. Signature and title of certifier | lenvet | 11 D | 9c. License number | 29d. D | Date signed (Month, | Day, Year) |
| V | 22y | | 30. Name and address of person who con | apleted cause of death (Item | 23a) (Type, Print) | SBURY | MD | 218 | 04. |
| | Sta Registra | - | 31. Date filed (Month, Day, Year) FFB 0 7 200 | 32. Registrar's Signat | Mr Anna | '." | | | |

| | | | | State of Maryla | | ent of Health and eate of Death | d Mental Hy | 20 | 108 | 05100 | |
|--|---------------------------------------|-------------|--|---|---|---|--|---|------------------|-------------------------|--|
| | Decedent's Name (First, Middle, Last) | | | | | | Reg. No. 2. Date of Death 3. Time of Death | | | | |
| _ | sicia | | Thomas | Blake | | | Month 2 | Day O4 | Year | 14.20 | |
| | ledic. imine | | 4a. Facility Name (If not institution, give s | | ps. | 4b. City, Town, | or Location of Dea | | | 1 (,) | |
| | | | Jesus fee | gional | Hospita | 1 Jessu | P, MD | An | ne A | rundel | |
| Fune | eral | | 5. Social Security Number UNK 6. Sex | 7. Age (In yrs | Moni | nder 1 Year If Under 24 H | 0 / | irth | | (State or Foreign | |
| Direc | tor | | | M 2□F 5 | Yrs. | July 110010 | | 9158 | MARYL | AND | |
| end *c | | | Usual Residence of Decedent 10a. State 10b. County | 10c. C | ity, Town or Location | | | | 10d Ir | nside City Limits | |
| Mary -f sh | | ট | MS AND LA | D Daine | SIENIA. | 12146 | | | | ☐ Yes 2 No | |
| r 288 | | Director | 10e. Street and Number | CITIE | 101. | Zip Code | | 10g. Citizen of | What Country? | | |
| h wit | | | 1455 GORDON | DR. | | 21061 | | 13. | SA | • | |
| aryland 21215-0020 should be filed within 72 hours after deeth with the Marylend and Mentel Hygiene. "retural" or terms 23a or 28a-f show innerted ovent | | Funeral | 11. Marital Status 1 | 2. Was Decedent Ever in I | J,S. 13. Was Do | ecedent of Hispanic Origin? specify Cuban, Mexican, Pu | (Specify Yes or N | o- 14. Rac | e - American In | dian, | |
| or it | | F. | 1 Never Married 2 Married | 1 ☐ Yes 2 ☑ No If Yes, Give | | s 2 No Specify: | erto moari, etc./ | | ck, White, etc. | | |
| bours | | d by | 3 ₩idowed 4 □ Divorced | Year or Dates: | | | | Specif | DIAC | _ | |
| 7 2 F | | Completed | 15. Decedent's Educ (Specify only highest grade | ation completed) | 16a. Decedent's t | Jsual Occupation work done during most of i Tuse retired) | working | 16b. Kind of B | usiness/Industry | 1 | |
| the iere. | | E | Elementary/Secondary (0-12) | College (1-4or 5+) | HEAVIED | WALLEST OA | 10TO1 | Cark | TRUCT | 72 | |
| T He He | | Be C | 17. Father's Name (First, Middle, Last) | | HEAVYER | 18. Mother's N | Name (First, Middle | | | 100 | |
| Aente de presentation de prese | | 6 | JAMES BLAKE SA | b | | Masy) | R. John | 300 | | | |
| Maryland 21215-0020 d 2 should be filed within 72 hours aff th end Mentel Hygiene. T is marked other than "netural" or | | | 19a. Informant's Name/Relationship (Typ | e, Print) | 19b. Mailing Add | ress (Street and Number or | | | State, Zip Code | 3) | |
| | | 1 | Thomas BLAKE JR. | SON | 1455 GO | ROON DR. Gle | EN BURN | SE, MI | -2106 | . (| |
| Peges 1 Peges 1 Int: If Item | 5 | 1 | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re | | Place of Disposition (cemetery, crematory | Name of | Date | 20c. Location | City or Town, S | itate | |
| Baltimore, permit. Peges 1 er Depertment of Heal Important: If Item 2 | | | 4 ☐ Donation 5 ☐ Other (Specify) | - AR | DENTCAL | MATORY | 2-9-05 | HANOVE | DR, M | P • | |
| Bal Bemir Deper | e) | | 21. Signature of Fureign Service Licenset | | | and Address of Facility augherty Family Funera | Home And Cro | mation Contor | DA | | |
| | | 1 | CXIVets | al X | | 2601 Mountain Ro | ad - Pasadena | , MD. 21122 | FaPle | | |
| | | | 23a. Part+. Enter the disease, or complic shock, or heart failure. List only one | ations that caused the dea cause on each line. | th. Do not enter the r | node of dying, such as card | liac or respiratory | arrest, | Inter | roximate val Between | |
| Physici /Medic | _ | | Onset and Death | | | | | | | | |
| Examin | _ | | disease or condition resulting in death) a. | Cardio- | | | rrest | | - | | |
| | | ē | | | or as a consequence | | | | į | | |
| cuted nd | | Examiner | Sequentially list conditions, Due to (or as a consequence of): | | | | | | | | |
| e exe | | Ĕ | if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury Cause, (Disease, (Disea | | | | | | | | |
| 68 / 60, // flicate be executed physician end is the burlet-trensit | - | ပ ၊ | that initiated events resulting in death) Last | Due to (c | or as a consequence | of): | | 1 | | | |
| X D Sertific ding p | | | | | | | | | | | |
| BOX Beth cer ettendir | | Physician/N | | | | | | | | | |
| Det the det de det the deteched | | Š | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | 23b. Did tobacco use contribute to the cause of death? | | | |
| thet nedb | Ē | 2 | Diabetes Meilitus | | | | 1 🗆 | Yee 2□ No | 3 Probably | 4 Unknown | |
| if VIII HECOLDS, P.O. BOX 68/60, yelclan: The law requires thet the deeth certificate be exacuted is certificate has been signed by the ettending physician and director, page 2 should be deteched for use as the buriel-trensit | 3 | | | | 24a. Was an autopsy 24b. Were autopsy findings | | | | | | |
| aw re | 1 | Completed | Hypertension | | | | perf | performed? available prior to completion of cau of death? | | ion of cause | |
| The It | | Ę | , , | | | | 10 | Yes 22 No | | 2□ No | |
| lan: atiffice ctor, | 000 | | 25. Was case referred to medical examiner? | Lanca Wall | | 26. Place of D | Death (Check only | one) | | | |
| Physic Physic this ce | 1 | 2 | 1 Yes 2 No Ho | | ER/Outpatient 3 | DOA Other: 4 Nursing | Home 5□Res | ome 5 Residence 6 Other (Specify) | | | |
| Ing P | | 5 | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injury at Work? | 28d. Describe | how injury occur | red | | |
| OVISION OF Attending efter death. Director: After | 3 | 200 | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be | oo- Blood Miles | M | 1 ☐ Yes 2 ☐ No | 00/ 1 | · | | | |
| or A Place of A Lin by | | | 4 ☐ Homicide determined | building, etc. (Special | . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | | City or To | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| spital sours nerei | 2 | | 29a. Certifiler (Check only (| | | | | | | | |
| LIVISION OF VICE To the Hospital or Attending Physician: within 24 hours effer death. To the Funerel Director: After this certific completely filled in by the funeral director; | legipo | | (Check only 2 ☐ Medical Examine one) | r: On the basis of examina and manner stated. | ition and/or investigat | ion, in my opinion, death oc | curred at the time, | date and place, | and due to the o | ause(s) | |
| To the To the Comp | 1 | | 29b. Signature and title of certifier 29c. License number | | | | | 29d. Date signed (Month, Day, Year) | | | |
| | | | Clack | | | D00/62 | 84 | 02/18 | 5410 | 3 | |
| 1 | | : | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | | | | | | | |
| 1 | | | GEDION | | , , | 1.0 | | | | | |
| | State | | 31. Date filed (Month, Day, Year) | . Registrar's Signa | ature | | | | | | |

08-01143 Arelyn M. Ballute Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 05101

| | D | -intros | Certificate of Death | | | | | | |
|---|---|---|---|--|---|--|--|--|--|
| Physicial edical Examin | n/ 1 | Arelyn M. Ballute | | ate of Death fonth Day Year 9, 2008 4c. County of Death | | | | | |
| | 4 | a. Facility Name (if not institution, give street and number) Calvert Memorial Hospital 4b. City, Tow Prince F | 1 | Calvert | | | | | |
| Funeral Director | | Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 46 Yrs. | Year If Under 24Hrs. Days Hours Min. | 8. Date of Birth (MM Sept. 24 1 | 961 Washington DC Country) | | | | |
| w any | 1 | Sual Residence of Decedent 10c. City, Town or Location 10c. City 10c. | | | 10d. Inside City Limits 1 Yes 2 No | | | | |
| ath with the Maryland stems 23a or 28a-f show any st be notified at once. | Director | 0e Street and Number 206 | ode O / | Unit | 10g. Citizen st.What Country? United States | | | | |
| c death with the Maryland or items 23a or 28a-f show must be notified at once | | Armed Forces? X Never Married 2 Married Armed Forces? X Yes 2 No | of Hispanic Origin? (Sp Cuban, Mexican, Puerto X No specify: | ecify Yes or No- Rican, etc.) | 14. Race - American Indian, Black, White, etc white Specify: | | | | |
| hours after "natural", Examiner | Completed by F | or Dates: | | red) | , Kind of Business/Industry | | | | |
|) 21215-0036 hould be filed within 72 hours after nd Mental Hygiene. is marked other than "natural", nite event, the Medical Examiner | ادہ | 17. Father's Name (First, Middle, Last) Roberto A. Parong | | rst, Middle, Maiden Surname) mberland | | | | | |
| MD 212 d 2 should be lith and Mentz m 27 is mark | ToB | 19a. Informant's Name/Relationship (Type, Print) James D. Ballute husband 19b. Mailing Address 303 Oak Drive | (Street and Number or F e Lusoy, MD 20 | <i>1</i> 007 | City or Town, State, Zip Code) | | | | |
| Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med | | 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name St. cresting Vibration) 4 Donation 5 Other Specify: | emetery Feb 15 | 5 2008 Pr | ic. Location - City or Town, State | | | | |
| Baltimore, permit. Pages l at Department of Hee Important: If ite | - 9 | 21. Signature of Funeral Service Licensee 4405 Bro | oddress of Facility areas Is. rd. I | fort Republi | C MD 20676 | | | | |
| Physician 'Medical aminer | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive cardiovascular disease | | | | | | | |
| | or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b. | | | | | | | | |
| ed nsit | Examiner | f any, leading to immediate Julie to (or as a consequence of): ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | |
| execut an and al - tra | <u>is</u> | X UNPENDED #MENDED 11,27, perME, C877, 3/4/08 | TT | | | | | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the fineral director, page 2 should be detached for use as the burial - transit | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Spec | 3 Ectopic pregr | nancy | 23d. Date of delivery Month Day Year | | | | |
| ords, P.O. Box 68' wrequires that the death certification is seen signed by the attending should be detached for use as | | 1 Yes 2 No 9 | | 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown | | | | | |
| Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the star after death. The alburdeath. Al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact | Completed by | Chronic alcoholism | | autopsy prior to completion of cause of death? | | | | | |
| Rec The la | l E | | 26.Place of Death (Chec | 1 Yes 2 | No 1 Yes 2 No | | | | |
| tal Rection: The certificate ector, page | Be (| 25. Was case referred to medical | Othor | | esidence 6 Other: | | | | |
| n of Vit Iing Physic After this funeral dire | on: To | 1 Ves 2 No | 28c. Injury at Work? 1 Yes 2 No | 28d. Describe ho | | | | | |
| Divisior all or Attend s after death | Certification: To | 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate b | Medical Ce | 4 Homicide 29a. Certifier (Check only one) 29a. Wedical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: Of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) | | | | | | | |
| To To To Con | Me ∈ | | c. License number | | 29d. Date signed (Month, Day, Year) | | | | |
| | | | O.C.M.E. | | February 10, 2008 | | | | |
| OCME | | Mary G. Rippie M.B. Bepary G. M. | Street, Baltimore, | , MD 21201 | | | | | |
| | State | 31. Date filed (Month, Day, Year) 32, Registrar's Signature | | | | | | | |

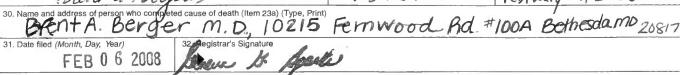
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Registrar AMENC#10ccerrH, 2/6/08, BW, MCC Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6:00A.M **Physician** Feb. 4, 2008 COHEN Sidney /Medical 4c. County of Death Montgomery 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Bethesda Brighton Gardens Nursing Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) 8. Date of Birth (Month, Day, Year) August 23,1915 Alexandria, VA 5. Social Security Number 226 42-7605 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days 1**√**□M 2□F **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County Bethesda 10d, Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Potomac Montgomery MD 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20852 550 Tuckerman Lane Funeral be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. WWII 1, Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No altimore, Maryland 21215-0036 Specify: White ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cohen Quality Shop Retailer 18. Mother's Name (First, Middle, Maiden Surname)
Bessie Sidel 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked of any lighty or other traumatic evonce. Cohen Abraham ဂ္ 19b. Mailing Address (Street and Number or Fural Royte Number City or Town, State, Zip Code) 5122 Wilson Lane, Bethesda, MD 19a. Informant's Name/Relationship (Type. Print) Joel Cohen / son 20b. Place of Disposition (Name of cemetery, crematory or other place).
King David Memorial Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) Feb. 5, 200% Falls Church, VA 3 □Removal from State 22. Na Gardens of Facility Torchinsky Hebrew Funeral Home 21. Signature of Fuller I S 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic carcinold **Physician** 3 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence of: Examine law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 aspiration presumonia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an was an autopsy performed?
Yes 2 No 1□ Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: Deliver | Specify | Specify | Other | Specify | 1 ☐ Yes 2 PNo 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural Injury To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier i 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

FEB 0 6



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 3:35 A M Edward W. Chojnowski, Sr. February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16 1st Street Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F Director 217-26-7129 77 11/5/1930 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be in 16 1st Street 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 2 Yes 2 □ No If Yes, Give Year or Dates: 1951–55 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Agricultural Chemistry Elementary/Secondary (0-12) College (1-4or 5+) 12th Laboratory Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) mit. Pages 1 and 2 should be file partment of Health and Mental Hyportant: If item 27 is marked oth y injury or other traumatic eventy Be Mary Radziszewski Wenceslaus Chojnowski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Vivian M. Chojnowski/ Wife 16 1st Street, Annapolis, MD 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 N Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or Lakemont Cemetery 2/7/08 4 Donation 5 Other (Specify) Davidsonville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Mu 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive **Physician** 78005 /Medical Due to (or s a consequence of): Examiner pheral rascular lisease Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examiner death certificate be executed and Due to (or as a consequence of) burial physician the burial P.O. Box 68760, Physician/Medical as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) the 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2□ No 2000 Division or Vital 1□ Yes 1 ☐ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 No 1 ☐ Yes မ 1 🔲 Inpatient To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 ⊟ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ebruary 4,2008 MO

CHLOH

Matthew J. Malta, M.D.

ate 31. Date filed (Month, Day, Year)
FEB 0 5 2008

. 132 Holiday Ct., Suite 201, Annapolis, MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

gegistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend#1 per Phy Axio HEALTH DEPT.

Registrar AMEND#17, 18 Per FH 2/12/08 CMH Certificate of Death

Registrar AMEND#17 Name (First Mark) 1.00 Per Physical Procedent's Name (First Mark) 1.00 Per Physical Phys 05104 Reg. No. 4 1. Decedents Name (First, Middle, Last) Blanca Iastenia Benitez Canas aka Blanca Iastenia Carcia Blanca Lastenia Benitez—Garcia 2. Date of Death 3. Time of Death **Physician** 1, 2008 11:53 A M February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F Months 68 Director 155-84-3074 <u>5/10/1939</u> El Salvador Usual Residence of Decedent 10a. State 10b, County 10c. City, Town or Location Show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Director Maryland Anne Arundel Annapolis 1 XYes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 501 Annapolitan Lane 21401 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 N Yes 2□ No Specify: El Salvadoran 2 Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 3rd College (1-4or 5+) Homemaker Home 12 should be filed w h and Mental Hygier ' is marked other th permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event; 17. Father's Name (First, Middle, Last, 18. Mother's Name, (First, Middle, Maiden Surname)
Guillerma Canas
Guillermina Canas Be Ildefonso Benitez Alfonso Benitez 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria M. Koch/ Daughter 83 Kiowa, Carbondale, CO 81623 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Signatural France Specific Licensee 2/9/08 Hillcrest Cemetery Annapolis, MD 22. Name and Address of Facility George P. Kalas Funeral Home Will 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ardiac /Medical Due to (or as a consequence of) Examiner 4 ocardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or s a consequence of) Examine law requires that the death certificate be executed and Due to (or as a consequence of): burial-Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 2 □ No 1 Yes 1 Yes 2 2 No Hospital or Attending Physiclan: 25. Was case referred to medical examiner? director. Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Teath 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day, Year) FEB 0 Registrar

HOWARD

5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Howard Vouns MD Anne A wandel Medical Center, Annapolis MS 2. Agistrar's Signature oun 32.

D0005829

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 734 PM 8,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 40 County of Death **Examiner** If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**M 2□ F Director 214-12-5745 90 11/30/1917 MD Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f shov ral", or items 23a or 28a-f shov Examiner must be notified at Director 1 Yes 2 No MD CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Battimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with t
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or a
myn injury or other traumatic event, the Medical Examiner must be n
once. 6402 CHURCH HILL RD. 21620 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: þ Specify: 3 XWidowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 ASSISTANT MANAGER SALVAGE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ဂ CHARLES COHEY ELLA IRELAND 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEPHEN COHEY/SON 360 ISLAND CREEK RD. CENTREVILLE, MD 21917 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) CRUMPTON, CEMETERY 02/13/2008 CRUMPTON, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 130 SPEER RD. CHESTERTOWN, MD 21620 boon tell 23a. Jart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ctesta /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last numanace Due to (or as a consequence of): Examine The law requires that the death certificate be executed My physician and s the burial-tran 00X1'x Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident hin 24 hours after death the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within To the 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) W 36 C30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K Delbo Church Hill Rd Cheskertown, MI) 21670 Freeleric MD 6602 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 0226 LEE C. COOK lanuary 31. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Eastch

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. albo Memoria-Social Security Number Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In yrs, last birthday **Funeral** 1**X** M 2□ F JUN 24,1927 Director 205-14-6700 80 PA Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified 1 ☐ Yes 2 X No Director MD TALBOT TRAPPE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code "natural", or items 23a or 27473 S. ISLAND CREEK ROAD 21673 USA Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23s 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1**X** Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: WHITE by 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DISTRICT SALES MANAGER STEEL CORPORATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LANGDON A. COOK P MARIE CARSKADDON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA COOK/DAUGHTER THOMAS COURT, KENNETT SQUARE, PA 19348 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION CTR 2/1/2008 STEVENSVILLE, MD 21. Signature of Funeral Service Licen FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Chronic Ob Structo yeurs disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a some equence of): Examine The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown þ signed I I be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an page 2 has autopsy certificate I 2 No 1∐ Yes Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 1 ☐ Yes P 1 🕰 npatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural Injury 5 Pending A hours after dec.

rati Director: A

in by the investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Acritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year)

5+IVA

State Registrar

31. Date filed (Month, Day, Year)

FEB 04

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death **Physician** Month Day Year 1202 AM Barbara F. Cropper 02 02 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner SallSbury

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Hospice Wicomico at the Lake oastal Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖾 F Director 220-28-0369 March 19, 1933 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10h. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Director 1 ☐ Yes 2 XINo MDWicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10691 Norris Twilley Road 21875 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XX No Specify: Completed by Specify: 3₺Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Schevel Louise Lord ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William M. Jones (Son) 320 Calvin Drive Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State = 5 Important: If any Injury o 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva Feb. 4, 2008 Delmar, Delaware 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Short Funeral Home 13 E. Grove Street Delmar, DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Br **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence, Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-tran and Due to (or as a consequence of): attending physician for use as the buria by Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 🗷 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an has page 2 autopsy performed' Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 DOther (Specify) HOSPICE 1 ☐ Yes 2 ☑ No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 A Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours a 1🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician: within To the

Maryland 21215-0036

Baltimore,

State Registrar

31. Date filed (Month, Day, Year) **FEB 0 6**

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO Mr BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD. 21801 32. Resistrar's Signature

and manner stated.

2008

29c. License number

D29505

29d. Date signed (Month, Day, Year)

and burial-tran Records, P.O. Box 68760, Division or Vital

1. Decedent's Name (First, Middle, Last) **Physician** Month Year 9, 02:30 P^M MELVIN BENTZ CARBAUGH **FEB** 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTERTOWN CHESTER RIVER MANOR KENT If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) Social Security Number 1 X M 2 □ F 203-10-0731 89 Nov 13, PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No MD Chestertown Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21620 USA 200 Morgnec Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify. White <u>ک</u> 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Procurement manager Appliance mfgr. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Eichholz Oscar A. Carbaugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1053 Sudlersville Rd., Church Hill, MD 21623 Tana R. Williams daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 MRemoval from State Strang's Cemetery 02/16/2008 South Mountain, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. Backersy 50 S. Broad St., Waynesboro, PA 17268 Pail. Enter the disease, or complications that cau ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resoluting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an autopsy 2 NO 1∏ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manufer stated. (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 006030 cause of death (Item 23a) 30. Name and address of person who completed CONESTANTONO, mil (G) Mich ajstrar's Signati 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEBRUARY 10, 2008 CATROW ELSIE S. 10:50P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WILLIAMSPORT WASHINGTON HOMEWOOD AT WILLIAMSPORT 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 92 Months Days Hours 234-24-4806 Director 9/26/1915 WEST VIRGINIA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No HARDY LOST RIVER **Funeral Director** W۷ 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 380 WALTER BELL LANE 26810 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) COHEN'S SALON Elementary/Secondary (0-12) College (1-4or 5+) OWNER/OPERATOR OF BEAUTY permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 is marked other I any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NELLIE CUSHWA CHARLES D. CATROW ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 380 WALTER BELL LANE, LOST RIVER, WV 26810 ANN HESS/NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) TUSCARORA PRESB CHURCH CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State **FEBRUARY** M□ Burial 2 □ Cremation 3 □ Removal from State MARTINSBURG, WV 4 ☐ Donation 5 ☐ Other (Specify) 13, 2008 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821 acles 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part1. Enter the disease, or complications that caused the death. Dy not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Die to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Uneace or injury that initiated events resulting in death) Last or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn 25. Was case referred to medical examiner? 26. Plage of Death (Check only on Other: Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mayner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation (Month, Day Year) 1 X Natural 2 Accident Injury 1 ☐ Yes 2 No Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a e Funeral I Medical 29a. Certifier Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature 29c. License number 29d. Date signed (Month, Dav. Year)

State Registrar 30. Name and address of

Date filed (Month, Day, FEB 2

2008

DHMH 17 Rev 1/2001

n was completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

| | | | For State | State of Mary | | artment of H | | , , | liene 2008 | 05110 |
|----------|--|----------------|---|---|--------------------------------------|--|--|---|---|--|
| | | i) | Registrar 1. Decedent's Name (First, Middle, Last) |) | | inouto or i | | 2. Date of Deat | th | 3. Time of Death |
| | Physicia | _ | SHIRLEY M. CAR | ATELLO | | | | FEBRUAR | RY 13 200 | 8 1:04 p ^M |
| | /Medic Examin | | 4a. Facility Name (If not institution, give s | street and number) | | 4b. City, Town, or | r Location of Death |) | 4c. County of Deatl | 1 |
| | | | Chester River | | | Cheste | | | Kent | |
| | Funeral Director | | 5. Social Security Number 6. Sec. 10 4 - 32 - 2555 | | In yrs. last birthday) 65 Yrs. | Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day NOV 23 | 1942 Pen | nplace (State or Foreign untry) insylvania |
| | D > | | Usual Residence of Decedent 10a. State 10b. County | 1 | 0c. City, Town or Lo | ncation | | | | 10d, Inside City Limits |
| | // Aaryla | ō | MD Queen A | | Cheste | | | | | 1 ☐ Yes 2X No |
| | the N 28a- | Director | 10e. Street and Number | | CITCOLE | 10f. Zip Code | | 1 | 0g. Citizen of What Co | untry? |
| | h with | <u>=</u> | 127 Wood Duck | Lane | | 21620 | | | U.S.A. | |
| | death | Funeral | | 12. Was Decedent Eve Armed Forces? | er in U.S. 13. | Was Decedent of H | lispanic Origin? (Stan. Mexican, Puert | pecify Yes or No- o Rican, etc.) | 14. Race - Amel Black, White | |
| 30 | 72 hours after death with the Maryland Inatural", or items 23a or 28a-f show dical Examiner must be notified at | by Fu | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | | 1 ☐ Yes 2 🛣 No | | | | hite |
| 2-003c | 2 hou latura ical E | ted | 15, Decedent's Edu | cation | 16a. Dece | dent's Usual Occup | oation | rking | 16b. Kind of Business/ | Industry |
| 7 | thin 7 e. an "n Medi | Completed | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4or 5+) | life. | DO NOT use retired | during most of wor d) | rking | Hood Com | a.a |
| 7 | ed wi ygien ner th it, the | S | 12 | | | Manager | 40. Mathavia Nau | no /Finak kilindala | Food Ser | vice |
| משם | l be fil ntal H ed oth ed oth | Be | 17. Father's Name (First, Middle, Last) Edward Burdett | - | | | | a Morris | | |
| Š | should nd Me mark matic | 은 | 19a. Informant's Name/Relationship (Ty | | 19b. Maili | ng Address (Street | | | r, City or Town, State, 2 | Zip Code) |
| <u> </u> | nd 2 saith ar 27 is rrtrau | | Louis W. Carate | | band) 12 | 27 Wood | Duck La | ane Che | stertown, | MD. 21620 |
| Ę, | ss 1 a of Hei | | 20a. Method of Disposition | 2 | 20b. Place of Dispo cemetery, cre | matory` or other plac | ce) | Date | 20c. Location - City or | |
| Ĕ | Page ment ant: If ury or | | 1 X Buria! 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) | | Lawn Ĉro | | | 9/08 | Linwood, | PA. |
| Баншог | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmoortant: If tiem 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 21. Sign flur of Funeral Service bioens | | 0510 | 2. Name and Addre Joseph A 1.450 Mar | ss of Facility A. Ward | Funera. | l Home od, PA. 1 | 9061 |
| | | | 23a. Rant. Enter the disease, or compl | lications that caused th | e death. Do not en | ter the mode of dyir | ng, such as cardiad | c or respiratory arr | rest, | Approximate Interval Between Onset and Death |
| F | Physician | 8 1 | shock, or hear failure. List only of Immediate Cause Final disease or condition | A | tonsequence of): | CASO | Shor : | OP CT COM | , | Onset and Death |
| 1 | /Medical | | resulting in death) | a. Le o (or as a c | consequence of): | CIP CIZOT | C 1.011 | | | |
| | Examiner | | Sequentially list conditions, | b | | | | | | |
| ~ | ted sait | nine | it any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Lua to (er sa a c | unaequance of): | | | | | |
| | execui and al-trar | Examiner | that initiated events resulting in death) Last | c Due to (or as a c | consequence of): | | | | | |
| 00/9 | certificate be executed ding physician and use as the burlal-transit | dical | | d | | | | | | |
| 0 | ntifica ng ph | Medi | IF FEMALE: | | | | | | | |
| X Q | death ce e attendi | ian/I | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome pf 1☐Live birth 2 | Fetal death 3 | ⊒Ectopic pregnanc | у | | 23d. Date of del Month | ivery Day Year |
| | w requires that the death certific been signed by the attending p should be detached for use as t | Physician/Med | 1 ☐ Yes 2 圖 No 9 ☐ Unknown | 4□Pregnant at tin 9□Unknown | me of death 51 | Other (specify) _ | | | | |
| , , | that the the the the the the the the the th | | Part II. Other significant conditions co | ntributing to death but | not resulting in the u | inderlying cause giv | ven in Part I. | 23e. Did to | bacco use contribute to | the cause of death? |
| 200 | requires that the een signed by the nould be detache | ed by | | | | | | 1 □ Y | ′es 2∏No 3∏Pr | obably 4 Unknown |
| ပ္သ | 250 | Completed | | | | | | 24a. Was a | an 24b. Were au | utopsy findings available |
| ř | r sician: The law s certificate has b lirector, page 2 s | Com | | | | | | perfor | rmed? death? | 2 No |
| N I Cal | cian: ertific ector, | Be C | 25. Was case referred to medical examiner? | 2-1 | | Lou | | ath (Check only or | ne) | |
| 0 | Physi this o | ၉ | 1 Yes 2 No 27. Manner of Death | Hospital: 1 ☐ Inpatient 28a. Date of Injury | | III 3 DOA | | Т | lence 6 Other (Spe | cify) |
| 0 | ding I h. After funer | tion: | 1 Natural 5 ☐ Pending | (Month, Day Y | | Wo | irk?]Yes 2∐No | Zou. Describe in | low injury occurred | |
| VISION | Atten deatl sctor: y the | fical | 3 Suicide 6 Could not be | Zoe. Flace of frigury | / - At home, farm, st | | | | Street and Number or Ru | ural Route Number, |
| 5 | al or | Certification: | 4 ☐ Homicide determined | building, etc. | (Specify) | | | City or Tow | /n, State) | |
| | To the Hospital or Attending Physician: The within 24 Hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page | edical (| | | xamination and/or i | | | | cause(s) and manner as date and place, and due | |
| | o the o the o the o the o the o the | Med | 29b. Signature and title of centifier | and manner state | ru, | 29c. Licens | se number | | 29d. Date signed (Mont | th, Day, Year) |
|) | ⊢≶⊢ŏ | | MI. U. 1 |) Z/ | | - Ne | 06030 | 1 | 2/15/10 | 8 |
| , | 6 | | 30. Name and address of person who c | ompleted cause of dea | th (Item 23a) (Type | | | , | - 1.510 | <u> </u> |
| | ン | | | lmer, M.D | . 122 8 | | l. Chest | ertown | MD. 216. | 20 |
| | Sta | | 31. Date filed (Month, Day, Year) | 32. Registrar's | s Signature | 80 | | | | |
| | Registr | al | FEB 2 1 2008 | ALY SON O | C Page | | | | | |

| | mend CHD, 2, 1748 ee Coats | | per FD, 2008, drw Please Type or Print in Black Indelible Ink. Ensure All Copies State of Maryland / Department of Health and Mental Hy For State amend #21 Per DVR G876 2420408 of Death | s Are Legi l ⁄giene | 20 | 08 0511 |
|------|--|-------------------|--|-------------------------------|------------------------------|--|
| | Physicia | R | edistrar Decedent's Name (First, Middle,Last) | 2. Date of Death | av Year | 3. Time of Death 1237 hrs |
| Medi | ical Exami | ner | Tora Lee Coates | January 27, | 2008 4c. County of Dea | |
| 3 | | | la. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Waldorf | | Charles | |
| | Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min. | _ | MM/DD/YYYY) 9. B | irthplace (State or ign ountry) MD |
| | | - | Jsual Residence of Decedent | | | 10d. Inside City Limits |
| | v any | | 10a. State 10b. County 10c. City, Town or Location | | | 1 Yes 2 X No |
| | land -f shov once. | ģ | MD Charles Waldorf Top Street and Number 10f Zip Code | 100 | . Citizen of What Co | untry? |
| | Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In marked to file and the state of the than "natural", or items 23a or 28a-f show Important: I filem 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. | Director | 5802 Opaleye Court 20603 | ĺ | USA | |
| | with th s 23a e notif | 盲 | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Status Armed Enroes? If Yes, specify Cuban, Mexican, Puerto | pecify Yes or No- | 14. Race - Am White, etc. | erican Indian, Black, |
| | r item | Funeral | 1 X Never Married 2 Married 1 Yes 2 X No | radan, oto., | Specify: | Black |
| | after o | by F | 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of | work done | 16b. Kind of Busines | |
| | hours 'natur | ted | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of the during most of working life. DO NOT use retained in the during most of working life. | ired) | | |
| | hin 72 e. than edical | Completed | 12 Police Sergeant | | Law Enfo | rcement |
| | 21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica | S | 17. Father's Name (First, Middle, East) | e (First, Middle, M | aiden Surname) Jones | |
| | 121 d be fil ental I arked avent, | Be | Herman Louis Coates Glady S 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or | | ber, City or Town, St | ate, Zip Code) |
| | Should and M 7 is m | ۵ | Gladys Coates/mother P.O. Box 624 Ches | sapeake | Beach, | MD 20732 |
| | and 2 and 2 Fealth item 2 traum | | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, company or other place) | Date | 20c. Location - City | |
| | ages lant of H | | 1 X Bunal 2 Cremation 3 Removal non-State So. Mem. Gardens 2/2 | 2/2008 | Dunkirk | |
| | Baltimore, MD opermit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati | | 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Science 1451 Dares Beau | ewell F | uneral Prince | lome: PA |
| | Physician | | Gladys A. Sevell M00523 per Dvr. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac | | | Approximate Interval |
| - 45 | | | failure. List only one cause on each line. | | | Between Onset and Death |
| V | aminer | | Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): | | | |
| | | | Sequentially list conditions, bb. | | | |
| | | aminer | if any, leading to immediate Due to (or as a consequence or): | | | |
| 15 | | | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | } |
| K | Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit | alE | dAMENDED | | | |
| 3 | O, e be ex ysician burial | Physician/Medical | GHI ENDES | - | 23d. Date of del | |
| alue | 68760, certificate bo nding physic ise as the bun | E | 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic preg | nancy | Month | Day Year |
| 2 | Box 6 e death cer the attendied for use | sicie | past 12 months? 4 | | | |
| Ü | the de cy the ched f | F | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | e to the cause of death? |
| | cords, P.O. law requires that the has been signed by 2 should be detach | ò | | - | | Probably 4 Unknown |
| -1 | rds, requir been s | etec | | 24a. Was | psy pric | re autopsy findings available r to completion of cause of |
| 16 | e law te has | Completed | | 1 ✓ Yes | ormed? dea 2 No 1 ✓ | Yes 2 No |
| A | ision of Vital Rec Attending Physician: The releath. Therefore After this certificate by the funeral director, page | ပိ | 25. Was case referred to medical 26.Place of Death (Che | | Residence 6 | Oth an Cases |
| | Vita hysicis this of | To B | 1 V Yes 2 No Impater 2 Literature Award 2 | rsing Home 5 | how injury occurred | |
| | ling P | = | 27. Manner of Death 1 Natural 5 Pending FOUND: 1 Yes 2 No | Subject sho | ot self | |
| | Sion Attender death ector: | cati | 2 Accident Investigation Jan 27, 2008 1237 hrs 28e Place of Injury - At home, farm, street, factory, office building, etc. | | | or Rural Route Number, City |
| | Division of Vital Records, pital or Attending Physician: The law requirement after death. After this certificate has been sittled in by the fineral director, page 2 should filled in by the fineral director, page 2 should | Certification: | Suicide 6 Could not be determined (Specify) Single Family | | e Court, Waldorf, | |
| | Hospit 24 hou Funer | | 29a Certifier . To the heat of my knowledge death occurred at the time, date and place, | and due to the cau | use(s) and manner a | s stated. e to the cause(s) |
| | Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Puneral Director: After this certificate has been signed by the attending physician and commissive filled in whe fineral director, page 2 should be detached for use as the burial - transit | Medical | 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred and manner stated. 29c. License number | ou at the time, udt | 29d. Date signed | (Month, Day, Year) |
| | L S F S |) ž | 29b. Signature and title of certifier 29c. License number O.C.M.E. | OCME | January 28, | |
| | | | Theoder M. King Thyours | | | |
| 10. | W 12 | | 30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltim | nore, MD 2120 | 01 | |
| de | | Stat | 32 Peristrar's Signature | | | |
| | | istra | JAIN 3 I LOUD BREWEI ST. MINERAL | | | |

DHMH 17 Rev 1/2001

Registrar

FEB 1 1 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Ada Aagaard Folkmann Der-Stepanian 10:05 February 04, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Potomac Valley Nursing Home Montgomery Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2**K** F Yrs. 81 578-48-8660 10, 1926 Denmark Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 N Yes 2 No Maryland Montgomery Burtonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code 14800 Silver Ash Court 20866 Denmark 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Doctor's Assistant 12 Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Karl Georg Folkmann Mary Christine Nielsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanna Der-Stepanian/ Daughter 19940 Wyman Way, Germantown, Maryland 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 2/7/2008 Brentwood, Maryland 21. Signature of Funeral-Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. En ar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate C rise (Final disease or condition resulting in death) meumoni Due to (or as a consequence of): SYEKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23d. Date of delivery Month Day Year

Physician /Medical Examiner

burial-transit

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygien Important: If Itam 27 Is marked other II any injury or other traumatic event. Its 2005.

Physician

/Medical

Examiner

10a. State

Funeral

Director

ral', or items 23a or 28a-f show Examiner must be natified at

Director

Funeral

þ

Completed

Be 2

with the Maryland

e filed within 72 hours after death is libygiene.

Baltimore, Maryland 21215-0036

Examiner Certification: To Be Completed by Physician/Medical IF FE 23b. Part II 25. W 27. Manner of Death 29a. Certifier Medical

1 ☐ Yes 2 No

5 Pending investigation

6 Could not be determined

FEB 06

Natural

√2 ☐ Accident

3 🗌 Suicide

29t

4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending charactering the control of the control

After this certific funeral director,

after death.

I Director: Aff

filled in by

Division of Vital Records, P.O. Box 68760,

| | d | | | |
|--|--|-------------------------|------------------------------|-----------------|
| MALE: Was decedent pregnant in the past 12 months? 1 Yes 2 No | 23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown | Fetal death 3 E | ctopic pregr Other (speci | nancy fy) |
| . Other significant conditions | contributing to death but no | ot resulting in the und | erlying caus | e given in Part |
| | | | | |
| /as case referred to medical | | | | 26. Plac |
| Yes 2 No | Hospital: | 2 ER/Outpatient | 3□ DOA | Other: |

28a. Date of Injury (Month, Day Year)

1 Certifying Physician: To the best of my knowledge, death

| 1. | 23e. Did tobacco use co | ntribute to t |
|----|-------------------------|---------------|
| | 1 ☐ Yes 2 No | 3 🗌 Prol |

| 23e. Did tobac | co use con | tribute to the cau | ise of death |
|----------------|------------|--------------------|--------------|
| 1 ☐ Yes | 2 No | 3 Probably | 4 Unkn |

| a. | Was an | 24b. | Were autopsy fi | ndings availab |
|-----|-----------|------------|-------------------|----------------|
| | 1 🗆 Yes | 3×No | 3 Probably | 4 Unknow |
| ,0. | Did tobac | co use con | INDUIG IO ING CAL | ise or dealing |

| . / | _ |
|--------------------------------|--|
| 24a. Was an autopsy performed? | 24b. Were autopsy findings availab prior to completion of cause o death? |
| ☐ Yes 2 No | 1 ☐ Yes 2 ☐ No |
| | |

| 26. | Place of Dea | ath (C | heck only o e) | |
|---------------|--------------|--------|--------------------|--------------------------------|
| r 24 | Nursing H | lome | 5 Residence | 6 ☐ Other (Specify) |
| at ? es | 2 🗆 No | 28d. | Describe how inj | ury occurred |
| | | 28f. | Location (Street a | and Number or Rural Route Numi |

| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Numb City or Town, State) |
|--|--|
| ian: To the best of my knowledge, death occurred at the time, date and place r: On the basis of examination and/or investigation, in my opinion, death occur | |

| one) Medical Examiner: On the basis of examination and/or investigand manner stated. | gation, in my opinion, death occurred at the tim | e, date and place, and due to the cause(s |
|--|--|---|
| . Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
| A ou de som | D38762 | GA 11 250 8 |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2401 Research Blvd., Rockville, Anurita Mendhiratta, M.D. 31. Date filed (Month, Day, Year)

State Registrar 32 Registrar's Signature

| | | | For | Pleas | | | | | delible Ink. artment of H | | | | .egible | | | |
|---|-------------------------------------|-------------------|--|--------------------------|----------------------------------|---|--|-------------------------------|---|--|----------------------------------|-------------|--|------------------|--|----------------------|
| | | _ | - State Registrar | | | | | Cer | tificate of | Death | | Reg. No. | 200 | 8 | 05 | 1 4 |
| | nysicia Medic | | ROIN DIGINE DILVED | | | | | | | | 2. Date of De Month 02 | oth ODay | 200 | r 8 | 3. Time of 6:15 | |
| No. 11 | xamin | | | | | | | 4b. City, Town, or Davidso | Location of Death | | 4c. County of Death Anne Arunde1 | | | | | |
| Fur | neral | | 5. Social Security Nu | | 6. Sex | | ge (In yrs. la | ast birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birt | h | 9. E | Birthpla | ace (State o | r Foreign |
| Dire | ector | | 579 28 86 Usual Residence of | | 1□M 2ሺ | F | 83 | Yrs. | Months Days | Hours Min. | 11/19/179 | 1924 | St | Lo | ouis M | 0 |
| aryland show | dat | _ | 10a. State MD | 10b. County | Arundel | | | Town or Lo | | | | | | 10 | od. Inside Cit | |
| n the M | notifie | Funeral Director | 10e. Street and Num | | | | Dav | ruson | 10f. Zip Code | | | 10g. Citize | en of What | Count | | 24110 |
| ath wits s 23a o | nust be | al D | 3895 Gree | nmeadov | | | | | 21035 | | | USA | | | | |
| DaltIIMOre, IMaryiand Z1Z13-UU36 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hyglene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show | xaminer n | by Fune | 11. Marital Status1 ☐ Never Marrie3 X Widowed | | Arme 1 1 Y | Decedeni d Forces es 2 2 Give or Dates: | | l: | Vas Decedent of H f Yes, specify Cuba I □ Yes 2∑ No | ispanic Origin? (Sp an, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | | Race - Ai Black, W Specify: | hite, e | | |
| IZIS-0036 vithin 72 hours af ne. han "natural", or | dical E | eted | | 15. Decedent' | | | | 16a. Deced | lent's Usual Occup | ation during most of work | ina I | 16b. Kin | d of Busine | ss/Inde | ustry | |
| within ene. | he Mec | Completed | Elementary/Secon | | Colle | ge (1-4or | 5+) | | kind of work done of NOT use retired robiologi | | ,,,,g | NIH | ī | | | |
| d be filed and Z | vent, t | Be C | 17. Father's Name (| First, Middle, L | | <u> </u> | L | 1110 | LODICIOGI | 18. Mother's Nam | e (First, Middle, | | | | | |
| naryianc 2 should be fi n and Mental H is marked ot | natic e | 2 | Nathanie | | | | | I | | Esther . | | | | | | |
| and 2 sh ealth and n 27 is n | er traum | | 19a. Informant's Na Victoria | L. Conl | | | | 3895 | g Address (Street a | dow Ln, | Davidson | | | | | |
| DallIMOFe, Dermit. Pages 1 at Department of Hea mportant: If item | ury or oth | | 20a. Method of Dispo 1 ☐ Burial 2 ☑ 4 ☐ Donation | Cremation | | rom State | _ ce | emetery, cren | sition (Name of natory or other place tan Crema | e) ; | /08 | | ation - City candri | | | |
| permit. Depart | any in | | 21. Signature of Fur | neral Service L | icensee | | | Ac At | Name and Addressivent Fundapolis | ss of Facility era1 & C MD 21401 | remation | n Ser | vices | | | |
| Physic | _ | | 23a. Part1. Enter th shock, or hear Immediate Cause (F disease or condition resulting in death) | Final | _a / | Net | ed the death. line. | Do not ente | | g, such as cardiac | | | | | Approximate Interval Bet Onset and E | ween |
| Exam | -40 | <u>_</u> | Sequentially list con | iditions, | b | | s a consecue | , | U | | | | | | | |
| executed in and | burial-transit | Examine | Sequentially list con cause. Enter Under Cause (Disease or is that initiated events resulting in death) La | rlying njury | c | | | , | | | | | | | | |
| ficate be ex | à | | , | | d | 9 10 (01 as | s a conseque | ence oi). | | | | | | | | |
| The law requires that the death certificate at been signed by the attending physis | should be detached for use as the l | Physician/Medical | IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 D 9 ☐ Unknown | months? | 1 □ L 4 □ P | ive birth | e pf pregnan 2 □ Fetal at time of de | death 3□ | Ectopic pregnancy Other (specify) | | | 23 | 3d. Date of o | | - | /ear |
| w requires that been signed b | pe q | 2 | Part II. Other signifi | cant condition | ns contributing | to death I | but not resul | ting in the un | derlying cause give | en in Part I. | 23e. Did to | , | | | e cause of d | |
| The lar | N | Completed | | | | | | | <u> </u> | | 24a. Was autop perfo | | 24b. Were prior 1 death | o com ? | esy findings anpletion of ca | available ause of |
| VILC ician; certific | ector, | Be | 25. Was case referre | | Hospital: | | | | Oth | 26. Place of Deat | | ne) | | | | |
| Phys | - T | 5 | 1 ☐ Yes 2 ☐ 1 27. Manner of D ath | | 28a. D | ate of Inj | ury | R/Outpatient 28b. Time of | t 3 DOA Othe | 4 Linursing Ho | me 5 Resid | | | oecify) |) | |
| ending Feath. | the funeral director, page | atio | 1 Natural 2 Accident | 5 Pending investiga | ation | Month, Da | ay Year) | Injury | | (? Yes 2 □ No | | | | | | |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certifica | ed in by t | Certification: | 3 ☐ Suicide 4 ☐ Homicide | 6 ☐ Could no determin | ned 28e. P | uilding, e | tc. (Specify) |) | eet, factory, office | | 28f. Location (S City or Tox | m, State) | | | | |
| ne Hospii n 24 hour ne Funer | completely filled in by | edical (| 29a. Certifier (Check only one) | Certifying | Physician: To xaminer: On the | the best basis of anner s | t of my know of examination tated. | ledge, death on and/or inv | occurred at the tin restigation, in my o | ne, date and place, pinion, death occur | and due to the red at the time, | cause(s) a | and manner place, and c | as sta lue to | ated. the cause(s | ·) |
| To ti withi To ti | Сош | | 29b Signature and | litle of certifier | 104 | 2/ | | (20) | 29c. License | 9166 | | 29d. Date | signed (Mo | onth, D | lay, Year) | 36 |
| 1004 | | | 30. Name and addre | Ma | ho completed of | cause of | death (Item 2 | 23a) (Type, F | 29c. License Drint) | St. C.12 | 101 E | claein | enter | N: | D 710 | 37 |
| Re | Stat egistra | e | 31. Date filed (Mont) | EB 0 5 | 2008 | 2. Pegist | rar's Signatu | ure | | 51. 50.11 | 1-1 | 9.00 | | , , , | | |
| DHMH 17 B | | | · · · · · · | | | | 100 X | - A | are . | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death **Physician** Month Day 4, 2008 3:00 A M Mary Morris Dalziel February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Village Health Care Center Montgomery Village Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan 31, 19 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 X F Director 281-22-1274 88 1920 Kansas Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location a or 28a-f show be notified at 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Montgomery Village Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with inent of Heatth and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or items 23a or;
Inty or other traumatic event, the Medical Examiner must be r 19100 Brooke Grove Court 20886 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No þ Specify. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Glen Albert Morris Elizabeth Anne Mark 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George T. Dalziel/husband 19100 Brooke Grove Ct. Montgomery Village, MD 20886 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of I Important: If its any injury or o once, 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory | 02/07/08 Beltsville, MD 21. Signatur 7 Funeral Service License 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Immediate Cause (Final disease or condition resulting in death) **Physician** Endstage Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner b. Electrolyte imbalance Sequentially list conditions Due to (or as a consequence of): Physician/Medical Examiner if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, physician the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autonsy 1∐ Yes 2**X** No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 XNursing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 2X No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b Time of Certification: Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation (Month, Day 1 X Natural ours after death.

neral Director: A
filled in by the fu 1 Tes 2 Accident 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined ò To the Hospital within 24 hours a To the Funeral C 29a. Certifier 🛣 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

5 EG.

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vinu Ganti, M.D. 19529 Doctor's Drive Germantown, MD 20874

31. Date filed (Month, Day, Year) 0 **FEB**

29b. Signature and title of certifier

29c. License number

D41162

29d. Date signed (Month, Day, Year)

February 6, 2008

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 11:50 A^M 2008 FREDERICK OSBON DUTTON, III FEB. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (If not institution, give street and number) Examiner KENT CHESTER RIVER HOSPITAL CHESTERTOWN 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F Director 84 FEB 24, 1923 VA 145-16-1463 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" -- "any injury or other traumatic event." 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 ☐ No Director CHESTERTOWN KENT MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 137 QUEEN ST. 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 2 □ No 1 ☐ Yes 2 📉 No Specify. δ Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PLASTICS **ENGINEER** 12 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ FREDERICK O. DUTTON, JR. ETHEL PUCKETT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 178 CHESTERTOWN, MD 21620 MACKEY DUTTON/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 2/11/2008 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 130 SPEER RD. CHESTERTOWN, MD 21620 P. ... Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-trar and Due to (or as a consequence of): Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown but not resulting in the underlying cause given in Part I. contributing to death 23e. Did tobacco use contribute to the cause of death? **À** 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an 1□ Yes 2 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 32 10 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3□ DOA P Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28c Certification: To the Hospital or Attending Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of o 29d. Date signed (Month, Day, Year) 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ferguson, MD 120 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

| | | | For State Registrar | State of M | aryland | | artment of H tificate of I | | nd Mental Hy | /gien Reg. N | 2000 | 05117 | |
|-------------------|--|----------------|--|---|--|-----------------------------|---|------------------------|--|--|------------------------------|--|--|
| | Physici | an | Decedent's Name (First, Midd | fle, Last) | | | | | 2. Date of D Month | eath | ay Year | 3. Time of Death | |
| 唐 | /Medic | | Bernice | | Datte | elbaun | | | Febru | ary | 5, 2008 | 6:53 a ^M | |
| | Examin | er | 4a. Facility Name (If not institution 1105 Riversion 1105 Riversio | | | | 4b. City, Town, or Salisb | | Death | 4 | 4c. County of Death Wicomico | | |
| . J., | Funeral | | 5. Social Security Number | 4 17 14 0 17 1 | je (In yrs. las | | If Under 1 Year Months Days | - | 4 Hrs. 8. Date of B Min. (Month, D | irth lav. Year | 9. Birth | place (State or Foreign | |
| L | Director | | 218-20-6366 Usual Residence of Decedent | 1□M 2 X F 8 | 39 | Yrs. | | | 8/20/1 | 918 | | yland | |
| | yland now at | | 10a. State 10b. County | у | 10c. City, | Town or Lo | cation | | | | | 10d. Inside City Limits | |
| | e Mar 3a-f sh tified | Director | | omico | Sal | isbur | . | | | | | 1 □Yes 2 No | |
| 21215-0036 | with th | Dire | 10e. Street and Number 1105 Rivers | ide Drive | | | 10f. Zip Code 2180 | 1 | | 10g. C | itizen of What Cou USA | ntry? | |
| | death ms 23 must | Funeral | 11. Marital Status | 12. Was Decedent | Ever in U.S. | 13. | | | in? (Specify Yes or N Puerto Rican, etc.) | 0- | 14. Race - Ameri | | |
| | ges 1 and 2 should be filed within 72 hours after death with the Maryland t of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | <u>چ</u> ا | 1 □ Never Married 2 □ Ma 3 🛣 Widowed 4 □ Divorce | If Yes, Give | | | f Yes, specify Cuba 1 □ Yes 2 ½ No | n, Mexican, Specify: | Puerto Rican, etc.) | | Black, White | , etc. white | |
| 15-0 | "natu "natu edical | letec | 15. Decede (Specify only high | nt's Education est grade completed) | | 16a. Deced | dent's Usual Occup kind of work done o OO NOT use retired | ation during most o | of working | 16b. | Kind of Business/Ir | ndustry | |
| 212 | filed withir Hygiene. ther than | Completed | Elementary/Secondary (0-12) | College (1-4or | 5+) | | sewife | " | | | domestic | | |
| pu | al Hyg I other vent, | BeC | 17. Father's Name (First, Middle | | | | | | s Name (First, Middle | | en Surname) | | |
| Maryland | 2 should be filed w n and Mental Hygie 'Is marked other t raumatic event, th | 2 | | amin | | | | | Rappapor | | | | |
| Mai | alth and 2 st alth and 27 is n | | 19a. Informant's Name/Relation Maxine Rosen/C | | | | | | or Rural Route Num | | | p Code) | |
| Baltimore, | jes 1 a of He if item or othe | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation | 3 □Removal from State | 20b. Plac | ce of Dispo netery, crer | sition (Name of natory or other place | e) | Date | 20c. l | Location - City or T | own, State | |
| tim | it. Pag rtment rtant: njury o | | 4 □ Donation 5 □ Other (| Specify) | Beth | | el Cemet | | 2/7/08 | | lisbury, | | |
| Ba | permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau | | 21. Signature Funeral Service | all | | 5 | OI Snow H | 1111 R | d., Salisk | oury | sional As , MD 2180 | ssociation)4 | |
| | | | 23a. Party. Enter the disease, constitution of the disease, constitution o | or complications that cause at only one cause on each li | | | er the mode of dyin | g, such as c | ardiac or respiratory | arrest, | | Approximate Interval Between Onset and Death | |
| | Physician /Medical | | disease or condition resulting in death) | a Due to (or as | | nce of): | | | | | | | |
| 4 | Examiner | | Sequentially list conditions | b | | | | | | | | | |
| | ed sit | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last | Due to (or as a consequence of): | | | | | | | | | |
| , | execut and al-tran | Examiner | that initiated events resulting in death) Last | ast initiated events ' c | | | | | | | | | |
| 68760, | icate be executed physician and s the burial-transit | edical | | | | | | | | | | | |
| | ertifica ling ph e as th | Med | IF FEMALE: | 00.15 | , | | | | | | | | |
| O. Box | The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown | 2 Fetal d | eath 3□ | Ectopic pregnancy Other (specify) | | | | 23d. Date of delive Month | very Day Year | |
| s, P.O | w requires that the d been signed by the should be detached | by Ph | Part II. Other significant condit | tions contributing to death b | ut not resulti | ng in the u | nderlying cause give | en in Part I. | tobacco | obacco use contribute to the cause of death? | | | |
| ord | require sen sig rould b | | | | | | | | 1 | Yes : | 2 No 3 □ Pro | bably 4 Unknown | |
| or Vital Records, | | Completed | | | | | | | | s an opsy formed? 2 X N | prior to co death? | opsy findings available ompletion of cause of 2 ☐ No | |
| Vita | Physician: Th r this certificate ral director, pag | Be | 25. Was case referred to medic examiner? 1 ☐ Yes 2 ☑ No | Hospital | ent 2∏EF | 3/0 | t all DOA Othe | Dr. | of Death (Check only | | | | |
| Or | ding Phys n. After this funeral di | n: To | 27. Manner of Death | 28a. Date of Inju | iry 2 | 8b. Time of | 1 3 DOA | y at | sing Home 5 Res 28d. Describe | | | ify) | |
| sior | ttending Fleath. tor: After the funera | atio | | tigation | y rear) | Injury | | Yes 2 □ N | 0 | | | | |
| Division | I or Att after de Direct in by t | Certification: | | mined Zoe. Flace Ut III | ury - At home c. (Specify) | e, farm, str | eet, factory, office | | 28f. Location City or To | | and Number or Rui ite) | al Route Number, | |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune. | edical C | | | best of my knowledge, death occurred at the time, date and place, and due to the asis of examination and/or investigation, in my opinion, death occurred at the time are stated. | | | | | | | | |
| | To the within To the Comple | Me | 29b. Signature and title of certification | or. | | | 29c. License | e number | | 29d. D | ate signed (Month | , Day, Year) | |
| | 00ch1 | | <u> </u> | 1, hm | | | | 04709 | 14 | | 2/6/08 | | |
| | A 20 | | 30. Name and address of person | who completed cause of a | leath (Item 2 | 3a) (Type, | Print) · DIV SM | ul | 84 5AZISBUM, | 1 | MD 2180 | 4 | |
| | Sta Registr | | 31. Date filed (Month, Day, Year FEB 0 | 8 2008 32. Rejsti | ar's Signatur | s A | best | | | | | | |

Sta

| or Print in Black Indelible Ink. Ensure | All Copies Are Legible. | A 1000 1 1 A |
|---|-------------------------|------------------|
| te of Maryland / Department of Health and | Mental Hygiene UU8 | 05118 |
| Certificate of Death | Reg. No. | |
| | 2. Date of Death | 3. Time of Death |

Month

Day

ΑM

Physician /Medical Examiner **Funeral**

1 - For State Registrar

Decedent's Name (First, Middle, Last)

Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show any Injury or other treumatic event, the Medical Event Let must be notified at once. Baltimore, Maryland 21215-0036

Raymond Davis

Physician /Medical

Division of Vital Records, P.O. Box 68760, After this certificate has

Examiner Examine nerel Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Completed by Physician/Medical Be 20 Medical Certification: within 24 hours after death. To the Funerel Director: A +5

25. Was case referred to medical examiner?

28 No

5 Pending

investigation

6 Could not be determined

1 Tes

27. Manner of Death

1 Natural

2 Accident

3 🗌 Suicide

29a. Certifier (Check only one) 29b. Signature and title of certi-

4 Homicide

31. Date filed (Month

| RAYMON | D T. DA | VIS, JR. | | | | | | | Feb | 2 | 20 | 800 | 12: | 40 AN |
|--|-----------------------|---------------------------------------|-----------------------------------|-----------|-------------|------------------|-----------------------|-----------------------|--------------------------------|----------------|--------------|--------------------|-----------|---------------------|
| 4a. Facility Name (| 'If not institution, | give street and number | r) | | 4b. City, | Town, o | r Location | of Death | | 4 | c. County | of Death | | |
| Genesis | s Heal | thCare - | The Pir | nes | | Eas | ston | | | | Τ | albo | ot | |
| 5. Social Security N | Number | | Age (In yrs. last b | | If Under | r 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Bi | rth av. Yea | <i>r</i>) | 9. Birthp | lace (St | ate or Foreigr |
| 158-09-9 | | 1 X M 2□ F | 89 | Yrs. | | ,- | | | oCT 1 | 7,19 | 18 | MAI | RYLAI | ND |
| Usual Residence of | 10b. County | | too City Te | | | | | | | | | | 04 11 | - Oh - Links |
| | , | | 10c. City, To | wn or Lo | | | | | | | | 1 | | de City Limits |
| MD | T | ALBOT | | | EAS' | TON | | | | | | | | Yes 2 XNo |
| 10e. Street and Nu | mber | | | | 10f. Zip | Code | | | | 10g. 0 | citizen of \ | What Cour | ntry? | |
| 39 KENS | INGTON | AVE. | | | | 216 | 01 | | | | U | SA | | |
| 11. Marital Status | | 12. Was Deceder Armed Force | nt Ever in U.S. | 13. \ | Was Dece | dent of H | lispanic Or | igin? (Sp | ecify Yes or N Rican, etc.) | 0- | | ce - Americ | | ın, |
| 1 🗆 Never Man | ried 2 X Marri | | ₹ No | | | | | | Thoan, oto., | | | | etc. | |
| 3 Widowed | 4 Divorced | Year or Dates | : | | 1 📮 Yes | 2 X I NO | Specify | | | | Specify | y: WH] | TE | |
| (Spe | 15. Decedent | s Education t grade completed) | 16 | a. Deced | dent's Usu | al Occup | ation | et of work | ina | 16b. | Kind of B | usiness/In | dustry | |
| Elementary/Seco | | College (1-4o | r 5+) | life. | DONOT | se retired | during mos d) | or work | iiig | | | | | |
| 12 | | 5+ | | CHEM | IICAL | ENG | INEER | 1 | | | ST | EEL | | |
| 17. Father's Name | (First, Middle, L | .ast) | | | | | | | e (First, Middle | , Maide | n Suman | ne) | | |
| RAYMOND | T. DAV | IS, SR. | | | | | MA | RIA | LOUISE | HUG | HES | | | |
| 19a. Informant's N | ame/Relationsh | ip (Type, Print) | 19 | b. Mailin | ng Address | (Street | and Numb | er or Run | al Route Numb | er, City | or Town, | State, Zip | Code) | |
| JONATHA | N H. DA | VIS/SON | | 519 | ACA | DEMY | ST. | HIIR | LOCK, 1 | m 2 | 1643 | | | |
| 20a. Method of Dis | | | 20b. Place | of Disno | sition (Na | me of | | | Date | | | City or To | own, Sta | te |
| 1X Burial 2 1 4 □ Donation | | 3 Removal from Stat | Θ | | natory or c | | | 0161 | 0000 | | | | | |
| 21. Signature of Fi | | | SPRIN | | | | EKY ; ss of Facili | and the second second | 2008 | EA | STON | , MAR | YLAI | ND |
| Las apin | - 4 | Detroush. C | f. s.P | FE | LLOW | S. H | ELFEN | BEIN | & NEWI | MAM MT | FUNE | RAL E | IOME, | , P.A. |
| 23a. Part1. Enter t | the disease, or a | complications that caus | ed the death. Do | | | | | | | | | | Approx | timate I Between |
| Immediate Cause | (Final | low | retrie | 10 | 5.11 | 1. Jus | •/ | | | | | | Onset a | and Death |
| disease or condition resulting in death) | ווכ | a Due to tra | is a consequence | of). | 471 | CIFIC | | | | | | | non | LAS |
| | | Hune | Luston | 3 01). | | | | | | | | | | |
| Sequentially list co | onditions, | b. Due to (or a | is a consequence | e of): | | | | | | | | | jew | |
| Cause (Disease or | 'iniury 1 | (i) | 1 | ,- | | | | | | | | | 4. | |
| that initiated events resulting in death) | S | c | IS a consequence | of): | | | | | | | | | yea | N |
| | | 555 (51 6 | is a consequence | 3 017. | | | | | | | | 6 | / | |
| | | d | | | | | | | | | | | | |
| IF FEMALE: | | | | | | | | | | | | 1 | | |
| 23b. Was deceden | | 23c. If yes, outcom 1 ☐ Live birth | ie of pregnancy 2 ☐ Fetal deat | th 3□ | Ectopic p | regnancy | , | | | | | te of delive | - | V |
| in the past 12 1 🗆 Yes 2 l | □No | 4☐Pregnant 9☐Unknown | at time of death | | Other (sc | | | | | | MO | onth | Day | Year |
| 9 🗆 Unknown |) | 9001110411 | | | | | | | | | | | | |
| Part II. Other signi | | s contributing to death | | | nderlying o | ause giv | en in Part I | l. | 23e. Did | tobacco | use cont | tribute to th | ne cause | of death? |
| Versine | kernia. | with enter | rudaneo | 16 1 | istul | - | | | 1 🗆 | Yes | 2 🗆 No | 3 🗌 Prob | ably 4 | Unknown |
| Steval | by | Hation | | | | | | | 24a. Was | an | 24b. ' | Were auto | psv findi | ings available |
| 11/11 | 1.00 | | | | | | _ | | auto | | | prior to condeath? | npletion | of cause of |

State Registrar

completed cause of death (Item 23a) (Type, Print)

DUTCHMAN'S LANG

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient

28a. Date of Injury (Month, Day Year)

29c. License number

Other:

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3□ DOA

26. Place of Death (Check only one)

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

DHMH 17 Rev 1/2001

| | 1 - Stata Registrar | | (| Certifica | te of E | Death | | | Reg. No. | 000 | |
|---|--|---|--|--|--|--|----------------------|--|--|--|---|
| : - · | 1. Decedent's Name (First, Middle, La | ast) | | | | | | 2. Date of De Month | eath Day | Year | 3. Time of De |
| ian ical | John S. | Davis | | | | | | Februa | | | 3:15 |
| ner | 4a. Facility Name (If not institution, gire | ive street and number) | | 4b. City | , Town, or | Location of | Death | | 4c. C | ounty of Death | h |
| | 201 Davis Road | | | 16 1 1 | Stre | | 4 Hen | | | Harfo | |
| | , | Sex 7. Age 1 XM 2 F | (In yrs. last birth | rs. Months | Days | If Under 2 Hours | Min. | 8. Date of Bir (Month, Da | ay, Year) | Co | hplace (State or Fo untry) |
| | 216-28-5654 Usual Residence of Decedent | | 81 ' | | | | | 8/18/ | 1920 | Mai | ryland |
| | 10a. State 10b. County | | 10c. City, Town | | | | | | | | 10d. Inside City L |
| ţċ | MD Harford | | Stre | et | | | | | | | 1 🗌 Yes 2[|
| Director | 10e. Street and Number | | | 10f. Zi | ip Code | | | | 10g. Citíze | on of What Co | untry? |
| al | 201 Davis Road | | | | 211 | 154 | | | Uni | ted St | ates |
| Funeral | 11. Marital Status | 12. Was Decedent E Armed Forces? | ever in U.S. | 13. Was Dece If Yes, spe | edent of His ecify Cubar | spanic Origi n, Mexican, | in? (Spe Puerto f | cify Yes or No Rican, etc.) | 0- 14 | Black, White | |
| by Fi | 1 Never Married 2 Married 3 XWidowed 4 Divorced | 1 ĀVes 2 □ No If Yes, Give Year or Dates: | o | 1 🗆 Yes | 2∰ No | Specify: | | | s | pecify: | White |
| ed b | 15. Decedent's E | | 16a l | Decedent's Usu | ual Occupa | ntion | | | 16b. Kind | of Business/l | Industry |
| Completed | (Specify only highest gr | rade completed) | | (Give kind of wi life. DO NOT L | ork done di | uring most | of workin | 19 | | | , |
| E | Elementary/Secondary (0-12) | College (1-4or 5+ | +) | Owner | r | | | | Golf | Course | 9 |
| BeC | 17. Father's Name (First, Middle, Las | st) | | | | 18. Mother | 's Name | (First, Middle | , Maiden S | umame) | |
| 10 B | Gladden Davis | | | | | Kat1 | heri | ne Str | eett_ | | |
| | 19a. Informant's Name/Relationship | | | Mailing Addres | , | | | | | _ | (ip Code) |
| | Kelly Louise Day | vis/Daughtei | | 01 Davis | | a, St | | | 2115 | | |
| | 20a. Method of Disposition 1 Durial 2 XCremation 3 [| ☐Removal from State | cemetery | Disposition (Na r, crematory or | other place | | | ate | | ation - City or | Town, State |
| | 4 ☐ Donation 5 ☐ Other (Special | | Evans | Eagle C | cremat | cory | 2/1 | 12/08 | Leol | a, PA | 11- 24- |
| | 21. Signature of Funeral Service Lice | nsee / | 1 1 | 22. Name a | | Acres and the same | | no r - | 600 | Main S | treet |
| | resulting in death) Sequentially list conditions. | Due to (or as a | osclero a consequence o | otic (| | | | a R | | ie | |
| at Examiner | Sequentially list conditions | b. — Due to (or as a | a consequence of | otic (| | | | | | re . | |
| dlcat | Sequentially list conditions | b. — Due to (or as a | a consequence o | otic (| | | | | | e | |
| edlcal | Sequentially list conditions | b. — Due to (or as a | a consequence of consequence of pregnancy | otic (| pregnancy | | | | liseas | id. Date of deli | Onset and Dea |
| Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No | Due to (or as a b | a consequence of a consequence of pregnancy 2 Fetal death time of death | ofic (f): f): 3 = Ectopic p 5 = Other (s | pregnancy | Liovas | | ar o | 23 | d. Date of deli | Onset and Dea |
| by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | Due to (or as a b | a consequence of a consequence of pregnancy 2 Fetal death time of death | ofic (f): f): 3 = Ectopic p 5 = Other (s | pregnancy | Liovas | | 23e. Did | 23 | id. Date of deli Month | onset and Dea |
| by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | Due to (or as a b | a consequence of a consequence of pregnancy 2 Fetal death time of death | ofic (f): f): 3 = Ectopic p 5 = Other (s | pregnancy | Liovas | | 23e. Did 1 | 23 tobacco use Yes 2 | d. Date of deliment of the del | Onset and Dea |
| Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | Due to (or as a b | a consequence of a consequence of pregnancy 2 Fetal death time of death | ofic (f): f): 3 = Ectopic p 5 = Other (s | pregnancy | Liovas | | 23e. Did 1 | 23 tobacco use Yes 2 | id. Date of deliment of the contribute to No 3 Proceedings of the Cont | onset and Dea |
| Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | Due to (or as a b. — Due to (or as a c. — Due to (or as a d. — 23c. If yes, outcome of the contribution of the contributing to death but | a consequence of a consequence of pregnancy 2 Fetal death lime of death | shc (f): f): 3 □ Ectopic p 5 □ Other (s) | pregnancy specify)cause give | n in Part I. | of Death | 23e. Did 1 1 24a. Was auto perfet 1 Yes (Check only) | tobacco use Yes 2□ san psy primed? 2 No one) | id. Date of deliment of the Month e contribute to No 3 prior to contribute to death? 1 Yes | onset and Dea |
| To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | Due to (or as a b. ———————————————————————————————————— | a consequence of pregnancy 2 Fetal death lime of death at not resulting in | ofic (f): f): 3 Ectopic p 5 Other (s) the underlying | pregnancy specify)cause give | n in Part I. | of Death | 23e. Did 1 24a. Was auto perfet 1 Yes [Check only ine 55] Resi | tobacco use Yes 2 | id. Date of deliment of the contribute to No 3 Processes of the prior to a death? 1 Yes | onset and Dea |
| To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Olisease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending | Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t 9 Unknown contributing to death but Hospital: 1 Inpatien 28a. Date of Injury (Month, Day | a consequence of pregnancy 2 Fetal death lime of death at not resulting in | shc (f): (f): 3 Ectopic p 5 Other (s) the underlying of jury | pregnancy specify)cause give | n in Part I. 26. Place or: 4 □ Nurs | of Death | 23e. Did 1 1 24a. Was auto perfet 1 Yes (Check only) | tobacco use Yes 2 | id. Date of deliment of the contribute to No 3 Processes of the prior to a death? 1 Yes | onset and Dea |
| To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | Due to (or as a b. ———————————————————————————————————— | of pregnancy Consequence of conse | shc (sh: | pregnancy ppecify) | n in Part I. | of Death | 23e. Did 1 24a. Was auto perfu 1 Yes Check only ne 5 Resi 8d. Describe | tobacco use Yes 2 san psy pormed? 2 No one idence 6 how injury | id. Date of deliment of the contribute to the co | the cause of deat obably 4 Munk topsy findings avacompletion of caus |
| Certification: To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | Due to (or as a b | a consequence of pregnancy 2 Fetal death time of death at not resulting in the consequence of the con | afic (f): 3 Ectopic p 5 Other (s) the underlying patient 3 D me of jury M m, street, factor | pregnancy precify) cause give 28c. Injury Work 1 Y ry, office | n in Part I. 26. Place of the American at ? yes 2 \(\text{Nurse} \) | of Death sing Home | 23e. Did 1 24a. Was auto perfect of the perfect only in the state of the control of the contr | tobacco use Yes 2 san psy pormed? 2 No one idence 6 how injury (Street and wn, State) cause(s) a | id. Date of deliment of the month of the contribute to the contribute of the contrib | onset and Dea |
| To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. If yes, outcome of 1 Live birth 24 Pregnant at t 9 Unknown contributing to death but 1 Inpatien 28a. Date of Injury (Month, Day) on be deep 28e. Place of Injury building, etc. | a consequence of pregnancy 2 Fetal death time of death at not resulting in the consequence of the con | shc (f): 3 Ectopic p 5 Other (s) the underlying of jury M m, street, factor death occurred for investigation | pregnancy precify) cause give 28c. Injury Work 1 Y ry, office | n in Part I. 26. Place of the American | of Death sing Home | 23e. Did 1 24a. Was auto perfect of the perfect only in the Styl Resident City or To and due to the | tobacco use Yes 2 san psy ormed? 259No one) idence 6 (how injury fixeet and wn, State) cause(s) a date and p | id. Date of deliment of the month of the contribute to the contribute of the contrib | onset and Dea |
| Certification: To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | Due to (or as a b. Due to (or as a c. Due to (or as a d. 23c. If yes, outcome of 1 Live birth 24 Pregnant at t 9 Unknown contributing to death but 1 Inpatien 28a. Date of Injury (Month, Day) on be deep 28e. Place of Injury building, etc. | a consequence of pregnancy 2 Fetal death time of death at not resulting in the consequence of the con | shc (f): 3 Ectopic p 5 Other (s) the underlying of jury M m, street, factor death occurred for investigation | pregnancy precify) cause give OA Othe 28c. Injury Work 1 Y | n in Part I. 26. Place of the American | of Death sing Home | 23e. Did 1 24a. Was auto perfect of the perfect only in the Styl Resident City or To and due to the | tobacco use Yes 2 san psy primed? 2 No one) idence 6 (how injury (Street and wn, State) cause(s) a date and p | id. Date of deliment of Month e contribute to No 3 prior to a death? 1 yes Other (Special Contribute of Rule) Number or Rule Indiana manner as lace, and due signed (Month) | onset and Dear Year ivery Day Year the cause of dear obably 4 Dunk topsy findings avacompletion of cause 2 No crify) ival Route Number to the cause(s) in Day, Year) |
| Certification: To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | Due to (or as a b. Due to (or as a c. Due to (or as a d. Due to (or as a d. Due to (or as a d. Pregnant at t 9 Unknown contributing to death but long to death but 28a. Date of Injury (Month, Day on be death death but 28b. Place of Injury building, etc. Physician: To the best of and manner state | a consequence of pregnancy 2 Fetal death time of death at not resulting in the consequence of the c | ation (s) 3 Ectopic p 5 Other (s) the underlying of jury M m, street, factor of jury M 29 | pregnancy precify) cause give OA Othe 28c. Injury Work 1 Y | n in Part I. 26. Place of the American | of Death sing Home | 23e. Did 1 24a. Was auto perfect of the perfect only in the Styl Resident City or To and due to the | tobacco use Yes 2 san psy primed? 2 No one) idence 6 (how injury (Street and wn, State) cause(s) a date and p | id. Date of deliment of Month e contribute to No 3 Production of Production of death? 1 Yes Other (Special Control of | onset and Dear Year ivery Day Year the cause of dear obably 4 Dunk topsy findings avacompletion of cause 2 No crify) ival Route Number to the cause(s) in Day, Year) |

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Certification: Director: n 24 hours the Funeral Dire 14 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 ms w 31. Date filed (Month, Day, Year) 32. Regis ar's Signature State 2008 Registrar DHMH 17 Rev 1/2001 **ORIGINAL**

| | | | For State Registrar | State of Marylan | Certificate of | | | no.2008 | 05121 |
|--|--|---------------------|--|---|--|---|---|---|--|
| | Physici | | Decedent's Name (First, Middle Agnes | Last) Frey-Sutter: | Ff old | | 2. Date of Death Month | Day 22008 | 3. Time of Death |
| | /Medic Examin | | 4a. Facility Name (If not institution, | give street and number) | | r Location of Death | | 4c. County of Deat | h |
| | Funeral | | | hington Mailal 6. Sex 7. Age (In yrs.) | | BUNU If Under 24 Hrs. 8 | B. Date of Birth | HMNR A | |
| | Director | | 408-40-0592 | ^{1 □ M} $\frac{2}{XX}$ 89 | Yrs. Months Days | Hours Min. i | (Month, Day, Yea an. 29,1 | | hplace (State or Foreign untry) etto TN |
| | yland now at | | Usual Residence of Decedent 10a. State 10b. County | | , Town or Location | | | | 10d. Inside City Limits |
| | he Mar 28a-f sl otified | ector | | rundel . | Hanover | · | | | 1 □Yes 2/NNo |
| | h with t 23a or 2 st be n | al Dir | 10e. Street and Number 7681 Tuckerman | Drive | 10f. Zip Code | 76 | 10g. (| Citizen of What Co USA | untry? |
|)\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\ | 72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notified at | by Funeral Director | 11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced | 12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes ※XXNo If Yes, Give Year or Dates; | S. 13. Was Decedent of H If Yes, specify Cub: 1 □ Yes 2 ☒ No | | ify Yes or No- ican, etc.) | 14. Race - Amer Black, White | |
| A-5 | 72 hou "natura | eted | 15. Decedent' (Specify only highest | s Education grade completed) | 16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired | oation during most of working | 16b. | Kind of Business/I | Industry |
| 25 | d within glene. r than the Me | Completed by | Elementary/Secondary (0-12) | College (1-4or 5+) | | ok | | Retreat | House |
| D B | be filed ntal Hyg rd othe event, | To Be C | 17. Father's Name (First, Middle, L Herman | | | 18. Mother's Name (i | First, Middle, Maid | | . 110 45 6 |
| Fig | should to the should to the should to the should to the should the should be | မှ | 19a. Informant's Name/Relationsh | Henke1 | 19b. Mailing Address (Street | Anna and Number or Rural I | Route Number. Cit | Hemm | |
| 五点 | and 2 ealth a m 27 is | | John Frey Son | | 7681 Tuckerma | n Drive Ha | | | |
| Saltimore | permit. Pages 1 and 2 should be filed within 72 ho Department of Heath and Mental Hyglene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical once. | | 20a. Method of Disposition 1X Burial 2 □ Cremation | | lace of Disposition (Name of emetery, crematory or other place red Heart | Dat 2/7/20 | 000 | Location - City or | |
| ali (| rmit. P spartme portan y Injur. | | 4 □ Donation 5 □ Other (Sp 21. Signature of Tureral Service L | | The state of the s | ss of Facility Funeral Hor | 50 | . Louis C | Co. Missouri |
| | 9 9 E E | | Datif | MI | 851 Annan | olds Dood | Combast 11. | MD 2105 | |
| | Physician | | Immediate Cause (Final | complications that caused the death nly one cause on each line. | . Do not enter the mode of dylin | ig, such as cardiac or r | respiratory arrest, | İ | Approximate Interval Between Onset and Death |
| | /Medical Examiner | | disease or condition resulting in death) | Due to (or as a consequ | ience of): | 2 | | | |
| N. T. | | Jer | Se uentially list conditions if any, leading to immediate | b. DNC BCTT | IE HEART | 4 AILUK | e | | |
| | tificate be executed g physician and as the burial-transit | Examiner | Se uentially list conditions if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | · Acute ? | ENAL FA | MURE | | | |
| 68760, | e be ex | | , | Due to (or as a consequ | ence or): | | | | |
| | ertificat ling phy e as th | Medical | IF FEMALE: | | | | | | |
| .0. Box | Attending Physician: The law requires that the death cer rdeath. ector: After this certificate has been signed by the attendin by the funeral director, page 2 should be detached for use | Physician/IV | 23b. Was decedent pregnant in the past 12 ponths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcome pf pregnal 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown | death 3 Ectopic pregnancy | 1 | | 23d. Date of deli Month | very Day Year |
| ds, P. | luires thai signed b Id be det | þ | Part II. Other significant condition | s contributing to death but not resu | Iting in the underlying cause give | en in Part i. | | o use contribute to 2 No 3 Pro | the cause of death? |
| ecol | law rec as beer 2 shou | Completed | | | | , | 24a. Was an autopsy | 24b. Were au | topsy findings available completion of cause of |
| a B | n: The | | | | | | performed? 1□ Yes 2 🗹 | yo death? 1 ☐ Yes | 2 No |
| r Vit | iyslciai iis certii directo | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No | Hospital: 1 Impatient 2 I | ER/Outpatient 3 DOA Othe | _26. Place of Death (0 er: 4 ☐ Nursing Home | | 6 ∏Other (Spec | eifv) |
| o uo | ding Physician: The lar n. After this certificate has funeral director, page 2 | | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | (Month, Day Year) | 28b. Time of lnjury 28c. Injury Worl | y at 280 k? | d. Describe how in | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |
| Division or Vital Records, | a Hospital or Attenc 24 hours after death 25 Funeral Director: etely filled in by the | Certification: | 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin | t be Ose Blace of injury At her | me, farm, street, factory, office | Yes 2 No 28f | f. Location (Street City or Town, Sta | and Number or Ru ate) | ral Route Number, |
| | Hosp 4 hou Fune ely fil | Medical O | 29a. Certifier (Check only one) 1 Certifying 2 Medical E | Physician: To the best of my know xaminer: On the basis of examination and manner stated. | vledge, death occurred at the tir ion and/or investigation, in my o | ne, date and place, and pinion, death occurred | d due to the cause at the time, date a | (s) and manner as and place, and due | stated. to the cause(s) |
| | To the I within 2: To the I complet | Me | 29b. Signature and title of certifier | | 29c. License | e number | 290 | Date signed (Month | n, Day, Year) |
| | | | 20 Name and address of | reg 2 | 2) (2) | 45149 | 100 | mand | 2, 2008 |
| C | #5 | < | 30. Name and address of person w | 301 Hocp | ital diver | Glen | Busie | e mi | 20161 |
| | Stat Registra | | 31. Date filed (Month, Day, Year) | 32. Kegistrar's Signat | ure | | | | - |

DHMH 17 Rev 1/2001

| | | For State Registrar | State of M | | artment of I rtificate of | | | giene | 08 05122 |
|---|------------------|--|---------------------------------|--|--|--|---|-------------------------------|--|
| * | | 1. Decedent's Name (First, Middle, I | ast) | | | | 2. Date of De Month | ath Day | 3. Time of Death |
| Physicia /Medica | | Elsie Ma | e Fle | ming | | | Februa | ry 6 | 2008 11:20 AM |
| Examine | and make | 4a. Facility Name (If not institution, g | ive street and number |) | 4b. City, Town, | or Location of Death | | 4c. Count | y of Death |
| 300 S | | Manokin | Manor | | Prine | cess Ann | 2 | Son | merset |
| Funeral | 7 | | . Sex 7. A | ge (In yrs. last birthday) | If Under 1 Year Months Days | If Under 24 Hrs. | 8. Date of Bir (Month, Da | th | Birthplace (State or Foreign Country) |
| Director | | 218-14-2418 | 1 □ M 2 X F | 88 Yrs. | WOILIS Days | Hodrs Hill. | 3/24/ | 1919 | Maryland |
| ъ. | | Usual Residence of Decedent | | T. 6. 7. 7 | | | | | 40d facide City Limite |
| aryla | | 10a. State 10b. County | | 10c. City, Town or Lo | ocation | | | | 10d. fnside City Limits 1 Yes 2 No |
| ith the Marylar or 28a-f show | 5 | Maryland Somer | set | Princes | | | | | |
| or 2 | | 10e. Street and Number | | | 10f. Zip Code | • | | | What Country? |
| ath w | <u>a</u> | 11974 Edgehill | | | 2185 | | | USA | |
| 17215-0036 within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ite Mari rat Exemiter in wather collified at | Funeral Director | 11. Marital Status | 12. Was Deceden Armed Forces | t Ever in U.S. 13. | Was Decedent of If Yes, specify Cut | Hispanic Origin? (Sp pan, Mexican, Puerto | pecify Yes or No Rican, etc.) |)- 14. Ra | ce - American Indian, ack, White, etc. |
| Seafte safte | by F | 1 ☐ Never Married 2 ☐ Married 3 【XWidowed 4 ☐ Divorced | If Yes, Give | | 1 ☐ Yes 2 ☑ No | Specify: | | Speci | _{fy:} white |
| 21215-0036 set within 72 hours aft giene. er than "natural", or the Medical Exerci- | D D | | Year or Dates | | dent's Usual Ossu | nation | | 16h Kind of S | Business/Industry |
| 7. 27 r | Completed | 15. Decedent's (Specify only highest) | grade completed) | (Give | dent's Usual Occu kind of work done | pation during most of work ad) | king | 16b. Kind of E | susiness/industry |
| 12 within | 립 | Elementary/Secondary (0-12) | College (1-4or | 5+) | ewife | 30) | | domes | tic |
| Hygird A | | 17. Father's Name (First, Middle, La | st) | noac | CWIIC | 18. Mother's Nam | ne (First, Middle | 1 | |
| Maryland d 2 should be file th and Mental Hy t7 is marked oth traumatic event | Be | Dora Washington | | | | Ida Ma | e France | es Niblo | ett |
| Maryland 2121 22 should be filed within h and Mental Hygiene. 71s marked other than "ir raumatic event, Ira Mar | ၉ | 19a. Informant's Name/Relationship | | 19b Maili | no Address (Stree | t and Number or Ru | | | |
| ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, it mandral Examinar invest be confilled at | | Charles F. Fle | | | | | | | y, MD 21804 |
| Baltimore, Mappernit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other transcent | | 20a. Method of Disposition | | 20b. Place of Disp | osition (Name of | | Date | 20c. Location | - City or Town, State |
| Baltimore, semit. Pages 1a Department of Her mportant: If Item | | 1 XBurial 2 ☐ Cremation 3 | | Portersy | matory or other plant in the U.M. | · I | 100 | | |
| ting transfer transfer transfe | 1 | 4 Donation 5 Other (Spe | 110000 | Church C | emetery | 2/9 | | | ton, MD |
| Dan permi | | 21. Signature of Funeral Service Lic | ensee | | Holloway | Funeral H | lome Pro | ression | nal Association |
| | | 23a. Part 1. Enter the disease, or co | | | | Hill Rd., | | 100 | Approximate |
| Physician /Medical Examiner | Examiner | shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ease. Extended the cause (Disease or injury | a Due to (or a | s a consequence of): | > | | | | Onset and Death |
| barbu, ilicate be executed g physician and as the burial-transit | edical Exar | that initiated events resulting in death) Last | c. Due to (or a | s a consequence of): | | | | | |
| BOX ath cert attendin for use | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | | 2 ☐ Fetal death 3 [| □Ectopic pregnand □ Other (specify) | су | | | ate of delivery Ionth Day Year |
| 15, P.O. | by Pr | Part II. Other significant conditions | s contributing to death | but not resulting in the t | inderlying cause g | iven in Part I. | | 2. 6 | ntribute to the cause of death? |
| w requir been si should | | | | | | | 10 | Yes 2 No | 3 Probably 4 Unknown |
| I VITAI RECORGS, ysician: The law requires t is certificate has been signe director, page 2 should be c | Completed | | | | | | 24a. Was auto perfe 1 Yes | | . Were autopsy findings available prior to completion of cause of death? 1 \sum Yes 2 \sum No |
| Vital F sician: Th s certificate lirector, pag | Be (| 25. Was case referred to medical examiner? | | | | 26. Place of Dea | th (Check only | one) | |
| Of V Physic | ၉ | 1 ☐ Yes 2 🐼 No | Hospital: 1 Inpa | tient 2 ER/Outpatie | nt 3□ DOA O | ther: 4 💆 Nursing H | ome 5□Res | idence 6 🗆 O | ther (Specify) |
| On C | | 27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accordant investigat | 28a. Date of In (Month, D | jury 28b. Time of Injury | W | uryat ork? ∏Yes 2 □ No | 28d. Describe | how injury occu | period |
| | Certification: | 2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine | be 28e. Place of I | njury - At home, farm, st etc. (Specify) | | | | (Street and Nun wn, State) | nber or Rural Route Number, |
| To the Hospital or within 24 hours afte To the Funeral Dir completely filled in | Medical C | | | it of my knowledge, dea of examination and/or in stated. | | | 1 | | |
| To th To th | ĭ | 29b. Signature and title of certifier | | | 29c. Licer | ise number | | 29d. Date sign | ed (Month, Day, Year) |
| V | | > din | | | | 147094 | | 21 | 6108 |
| 481 | | 30. Name and address of person when the state of the stat | no completed cause of | death (Item 23a) (Type | , Print) | SALISA | sury | MD 21 | 804 |
| Stat Registra | _ | 31. Date filed (Month, Day, Year) FEB 0 8 | 2008 32. Agis | death (Item 23a) (Type | lack. | | | | |

| | | | for State Registrar | State o | of Maryla | | artment of I rtificate of | | nd Mer | | ene 20 (| 08 | 05 | 123 |
|----------------|--|--------------------|--|---|----------------------------------|--------------------|---|-----------------------------------|----------------------------|---------------------------|--------------------|---|-----------------------------|----------------|
| | 6 4 | | Decedent's Name (First, Middle | e, Last) | | | imouto or | Death | 2. | Date of Death | . No. | | 3. Time of | Death |
| | Physici | | | ertram | Foodi | ck, Sr. | | | | Month bruary | Day 2 20 | Year | 8:37 | P ^M |
| | /Medio | | 4a. Facility Name (If not institution | | | CK, DI. | 4b. City, Town, o | or Location of D | | bruary | 4c. County of | | 0:37 | Г |
| | LAGIIII | iei O | 6605 Buffalo | | , | | 1 | It. Air | 77 | | | rrol1 | 1 | |
| | Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In y | rs. last birthday) | If Under 1 Year | If Under 24 | Hrs. 8. | Date of Birth | | 9. Birthpla | ace (State o | r Foreign |
| | Director | | 550-36-5011 | 1 🖾 M 2 🗆 F | 77 | Yrs. | Months Days | Hours 1 | | (Month, Day, Yo | | Counti Ohi | | |
| | P. | | Usual Residence of Decedent | | | | | | | | | | | |
| | rylar how lat | L | 10a. State 10b. County | | 10c. | City, Town or Lo | cation | | | | | 10 | d. Inside Ci | |
| | e Ma Sa-f s | 양 | Maryland Car | roll | | Mt. | Airy | | | | | | 1 ☐ Yes | 2⊠No |
| | iff th | Directo | 10e. Street and Number | | | | 10f. Zip Code | | | 10g | . Citizen of Wh | nat Count | ry? | |
| | 23a ust t | | 6605 Buffalo | Road | | | 21 | 771 | | | Unite | d Sta | ates | |
| | tems | Funeral | 11. Marital Status | Armed F | | U.S. 13. | Was Decedent of I f Yes, specify Cub | Hispanic Origin an, Mexican, P | n? (Specify Puerto Rica | / Yes or No- an, etc.) | 14. Race Black, | America White, e | | |
| 36 | s afte | by F | 1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced | 15 \$ 600 (| 2□No ive Dates: Ko1 | | 1 ☐ Yes 2 🔀 No | Specify: | | | Specify: | Ţ | White | |
| 21215-0036 | hour fural | 8 | | t's Education | Jales. KO | - | ient's Usual Occu | nation | | 1 16 | b. Kind of Bus | inass/Ind | ueto. | |
| 5 | in 72 n "na fedio | Completed | (Specify only highe | st grade completed) | | (Give | kind of work done | during most of ed) | f working | | b. tand or bas | 11033/11101 | ustry | |
| 2 | with jiene r tha | E O | Elementary/Secondary (0-12) | College (| 1-40r 5+) | 1 | ectronic | | | U | efense | Cont | racto | r |
| Ö | be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notitied at | Be C | 17. Father's Name (First, Middle, | Last) | | | | | | irst, Middle, Mai | | | | ~ |
| Maryland | uld be fenta rked ric ev | To B | Allen Eugene | Fosdick | | | | Hele | en Mc | Manus | | | | |
| az | and 2 should be filed within 72 hours after death with the Marylan leath and Mental Hygiene. m 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, the Medical Examiner must be notified at | _ | 19a. Informant's Name/Relations | | | 19b. Mailir | g Address (Street | - | | | City or Town, S | tate, Zip (| Code) | |
| | ートトロ | | Marian J. Fosd: | ick / Wif | e | 6605 | Buffalo | Road M | Mt. A | iry, Ma | rvland | 2177 | 71 | |
| S. C. | e = | | 20a. Method of Disposition | | 20b | . Place of Dispo | sition (Name of natory or other pla | | Date | 200 | c. Location - C | | | |
| altimore, | Pages nent of int: If its iry or o | | 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S | | State | | re Cemete | ' T. 6 | ebrua , 200 |)8 M | it. Air | v. Ma | arvlar | ıd |
| a | permit. Pages Department of Important: If it any Injury or conce. | | 21. Signature of Funeral Service | Licensee | | 22 | . Name and Addre | ess of Facility | Stau | | | | | |
| m | 9 2 E 8 | | The state of the s | Jula | | 8 | E. Ridge | ville E | Blvd. | Mt. A | iry, Ma | ary1a | and 21 | 771 |
| | | | 23a. Part1. Enter the disease, or shock, or heart failure. List | complications that only one cause on | each line. | | | • | | | | | Approximate Interval Bet | eween |
| | Physician | | Immediate Cause (Final disease or condition | | Sevi | ere l | End St | ogs C | hrone | Obstrute | ie fuln | MIX | Onset and [| Death |
| | /Medical | | resulting in death) | Due to | (or as a cons | | | | | | | | | 107.5 |
| | Examiner | L | Sequentially list conditions, | b | | | | | | | | | | |
| J. P. | ed sit | iner | ri arry, leading to immediate | Due to | (or as a cons | aquanta oi). | | | | | | | | |
| | ecut and I-tran | Examin | Cause (Disease or injury that initiated events resulting in death) Last | c | (or as a cons | equence of): | | | | | | | | |
| Ď, | icate be executed physician and s the burial-transit | | | Due to | (or as a cons | equence or, | | | | | | | | |
| 58760, | phys phys the | dical | | d | | | · · · · · · · · · · · · · · · · · · · | | | - | | | | |
| _ | certif iding se as | Physician/Me | IF FEMALE: | 23c. If yes, ou | tcome of pred | inancv | | | | | and Date | at stalling | | |
| ROX | atter for u | ciar | 23b. Was decedent pregnant in the past 12 months? | 1 ☐ Live | birth 2□Fe | etal death 3 | Ectopic pregnanc Other (specify) | у | | | 23d. Date Mont | | | /ear |
| j. | the d | ysic | 1□Yes 2□No 9□Unknown | 9□Unkn | | rueam J_ | Jotner (specify) _ | | | | | | | |
| _ | ician: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use as | | Part II. Other significant condition | ons contributing to d | eath but not re | esulting in the ur | nderlying cause giv | ven in Part I. | | 23e. Did tobac | co use contrib | oute to the | e cause of d | eath? |
| g | luires 1 sign 1d be | d by | _ Osteoporo | 1515 | | | | | | 1 XYes | 2 No 3 | 3 ☐ Proba | ıbly 4 □L | Jnknown |
| Vital Records, | law req as beer 2 shou | Completed | COPONARY | BRTER | 1 01 | SEASE | | | _ | 24a. Was an | 24h W | ere auton | sy findings a | available |
| Ž | The la | E C | - 0 (0) (1 / 1 / 1 | 17 (17) | | | | | | autopsy performed | pri | ior to com | pletion of ca | ause of |
| <u>a</u> | ificate | e Co | 25. Was case referred to medical | | | | | 00 Di/ | · D · II · (0 | | ₹No 1 [| □Yes 2 | 2□ No | |
| | Physician: this certific al director, | o Be | examiner? | Hospital: | Inpatient 2 | ☐ ER/Outpatien | Oth | 00r: | | heck only one) | | · · · · · | | |
| Ö | ding Physics After this continues of funeral directions of the continues o | $\vdash \parallel$ | 27. Manner of Death | 28a. Date | of Injury | 28b. Time of | | | | 5 Residenc | | | | |
| DIVISION | nding th. :: Afte | igi Igi | 1 Matural 5 ☐ Pendin 2 ☐ Accident investio | 9 | nth, Day Year) | Injury | | rk? Yes 2∐No | | | | | | |
| N S | Atte or des by th | iii iii | 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ | inad Zoe. Flatt | of injury - At ing, etc. (Spe | home, farm, stre | eet, factory, office | | 28f. | Location (Stree | et and Number | r or Rural | Route Num | ber, |
| 5 | s after al Dir | Certification: | | bulla | ing, etc. (<i>ape</i> | City) | | | | City or Town, S | siaie) | | | |
| | hour hour uners sly fills | | 29a. Certifier 1 Certifyin (Check only 2 Medical | g Physician: To the Examiner: On the b | e best of my k | nowledge, death | occurred at the ti | me, date and p | place, and | due to the caus | se(s) and man | ner as sta | ited. | |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer | Medical | one) | and man | iner stated. | | | | occurred a | at the time, date | and place, ar | id due to | ine cause(s | , |
| | With Con | Σ | 29b. Signature and title of certified | M. | (| 0 10 | 29c. Licens | | | | Date signed | | | |
| | sp. | | from 1. | 1 the | ~ | IND | D | 114 | 44 | | 4151 | 08 | | |
| 1 | XC | | 30. Name and address of person | who completed caus | | em 23a) (Type, | Print) D | EX AVE | 6 # | 204 6 | BLACK | CK | noh ? | 1702 |
| _ | | | JAMES S. 31. Date filed (Month, Day, Year) | 00.5 | | | | S. 7.70 | | | , 500-11 | | INU L | , , - |
| | Sta Registr | | The Park Inc. | 7 2008 | Police | nature A | noute | | | | | | | |

DHMH 17 Rev 1/2001

| | | | For State Registrar | State of Mary | _ | artment of F <i>tificate of</i> | | - | giene Reg. No. 200 | 8 05 124 |
|------------|---|----------------|---|---|--|--|--|--------------------------------------|-------------------------------------|---|
| Ġ. | Physici | an | 1. Decedent's Name (First, Middle, Last |) | | | - | 2. Date of De Month | eath Day Ye | 3. Time of Death |
| | /Media | al | LEO A | FUHRMANN | | 4h Cihi Tours d | r Leasting of Doct | FEBRUAI | RY 1 20 | 008 9:02 A M |
| | Examir | er | 4a. Facility Name (If not institution, give FREDERICK MEMORIA | | | FREDER | r Location of Deatl | n | 4c. County of E | |
| | Funeral | | 5. Social Security Number 6. Se | x 7. Age (Ir | yrs. last birthday) | If Under 1 Year Months Days | | 8. Date of Bir | th 9 | Birthplace (State or Foreign Country) |
| ign. | Director | | 577-32-9340 | 81M 2□F 80 | Yrs. | monano bayo | Tiodio IIIII. | June 2. | 5, 1927 Wa | shington, DC |
| | land ow | | Usual Residence of Decedent 10a. State 10b. County | 10 | c. City, Town or Lo | cation | | | | 10d. Inside City Limits |
| | Mary a-f sh ified a | tor | Maryland Frederic | 2k | Mt. | Airy | | | | 1 ☐ Yes 2 ☑ No |
| | or 28 | Director | 10e. Street and Number | • | | 10f. Zip Code | | | 10g. Citizen of Wha | t Country? |
| | s 23a | rall | 14106 Harrisvill | | | | 771 |) | United | States American Indian, |
| 5-0036 | 172 hours after death with the Maryland "natural", or items 23a or 28a-f show idical Examiner must be notified at | by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Ever Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: W | | Was Decedent of H f Yes, specify Cub I∏Yes 2☑ No | Ispanic Origin? (San, Mexican, Puer Specify: | ipecify Yes or No to Rican, etc.) | Specify: | White etc. White |
| 5-0 | s 1 and 2 should be filed within 72 hc if Health and Mental Hygiene. Item 27 is marked other than "natu other traumatic event, the Medical | Completed | 15. Decedent's Edu (Specify only highest grad | ication le completed) | 16a. Deced | dent's Usual Occup kind of work done OO NOT use retire | nation during most of wo | rking | 16b. Kind of Busin | ess/Industry |
| 2121 | within lene. than " | dmo | Elementary/Secondary (0-12) | College (1-4or 5+) | | nanical D | • | | Rese | arch |
| d 2 | illed Hygi other ent, t | Be Co | 17. Father's Name (First, Middle, Last) | | TICCI | ianiteat b | | me (First, Middle | , Maiden Surname) | aren |
| /lar | uld be Menta arked artic ev | To B | Leo A. Fuhrmann, | Sr. | | | Thelma | Nichols | 3 | |
| Maryland | d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "I traumatic event, the Med | 1 | 19a. Informant's Name/Relationship (T | · · · · · | | • | | | er, City or Town, Sta | . , , |
| | 1 and 2 Health em 27 i | T G | Minarose Fuhrma 20a. Method of Disposition | | 14106 20b. Place of Dispo cemetery, cren | | | d Mt. A | Airy, Mary | 1and 21771 |
| JOL | ages ent of nt: If it | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ I | removal from State | cemetery, cren Garrison | | ce) Feb | ruary 2008 | Owings Mi | lls, Maryland |
| Baltimore, | permit. Pages 1 an Department of Heal Important: If item 2 any injury or other | | 21. Signature of Funeral Service Licens | | 22 | 2. Name and Addre | ess of Facility St | tauffer | FuneralHo | |
| | | | 23a. Part1. Enter the disease or omp shock, or heart failure. List only of | lications that caused the | | | | | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | a. C | 01000 | Stile | 1 | ase | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as a co | onsequence of): | 2.4 |) | - | | |
| | nted I | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a co | onsequence of): | | | | | |
| 68760, | icate be executed physician and s the burial-transit | edical Exa | resulting in death) Last | Due to (or as a co | insequence of): | | | | | |
| | | Med | IF FEMALE: | | | | | | | |
| P.O. Box | the death certific y the aftending p iched for use as t | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome pf p 1 □Live birth 2 □ 4 □Pregnant at tim 9 □ Unknown | Fetal death 3 |]Ectopic pregnand]Other <i>(specify)</i> _ | у | | 23d. Date o Month | f delivery Day Year |
| | w requires that the de been signed by the a should be detached f | ρ | Part II. Other significant conditions of | ntributing to death but no | ot resulting in the ur | nderlying cause gi | ven in Part I. | | tobacco use contribu Yes 2 No 3[| te to the cause of death? Probably 4 Unknown |
| I Records, | hysician: The law re his certificate has bee I director, page 2 sho | Completed | | | | <u> </u> | | 24a. Was auto perf 1∐ Yes | ppsy prio ormed dea | re autopsy findings available r to completion of cause of th? |
| /ita | cian: ertifica ector, | BeC | 25. Was case referred to medical examiner? | 114-5 | | | | ath (Check only | | |
| or Vital | Physician: r this certific ral director, | ဥ | 1 Yes 2 No 27. Manper of Death | Hospital: 1 ☐ Inpatient 28a. Date of Injury | 24 ER/Outpatien 28b. Time of | IL 3 LI DOA | | | idence 6 Other (| Specify) |
| O | Attending Phys r death. ector: After this by the funeral di | tion | 1 Natural 5 Pending 2 Accident investigation | (Month, Day Ye | ear) Injury | Wo | ryat rk? ∣Yes 2 ∐ No | Zod. Describe | now injury occurred | |
| Division | | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of injury - building, etc. (S | At home, farm, str Specify) | eet, factory, office | | 28f. Location (City or To | (Street and Number own, State) | or Rural Route Number, |
| | To the Hospital or within 24 hours afte To the Funeral Dir completely filled in | Medical (| | rsician: To the best of m iner: On the basis of exa and manner stated | amination and/or in | | | | | |
| | To the within To the comp | Me | 29b. Signature and title of certifier | ~ ~ | | 29c. Licen: | se number | | 29d. Date signed (A | Month, Day, Year) |
| | , NAC | | MIA | - U, O | / | H405 | 39 | | February | 1,2008 |
| 1 | of Mi. | | 30. Name and address of erson John Moleswor | th, M.D. 4 | 00 W. Sev | enth Str | eet Fre | derick, | Maryland | 21701 |
| | Sta Registi | te ar | John Moleswor 31. Date filed (Month, Day, Year) FEB 0 7 20 | 08 32 Jegistrar's | Signature | all I | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Fisher 2:45A. Katherine February 10, 2008 Laura /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Cumberland Allegany Memorial Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Social Security Number **Funeral** Months 1 M 2 F MD Feb 13, 1914 Director 93 212-38-7146 Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ¥Yes 2 □ No Cumberland MD Allegany Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 717 Glenmore Street Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo Specify. Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Homemaker</u> Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cora (Hager) Spriggs William P. Spriggs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WV 26722 HC 86 Box 3 Green Spring Lee Fisher son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Kurial 2 □ Cremation 3 □ Removal from State 2/12/2008 Sunset Memorial Park MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign store of Funeral Service License 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23s. Dany Enter the disease, dromplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme fate Cause (Final disease or condition resulting in death) **Physician** 24 HOURS ACUTE CARDIOVASCULAR ACCIDENT /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Due to for as a consequence of Completed by Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): physician IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 2□ No 1 🗆 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To 27. May er of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760,

or Attending To the Hospital

To the Funeral Director: completely filled in by the within 24 hours a To the Funeral L

State

Registrar

29b. Signature and title of certifier

and manner stated.

29c. License number D-14865

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

February

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500 MEMORIAL AVE., SUITE 201, CUMBERLAND MD 21502 ROBUSTIANO J. BARRERA,

31. Date filed (Month, Day, Year)

29a Certifier

FEB 21



ennig,

| | | | 1 = For AMEND#23b per Prostate Registrar 2/5/08 AACO | Y. State of M | Maryland . | Dep Ce | artment <i>rtificate</i> | of Hea | alth and eath | d Men | | iene eg. No. 2 | 008 | 05126 |
|--------------------------------|---|----------------------|--|--|--|---------------------------------|---|-------------------------|---|---------------|--|-----------------------|-------------------------|---|
| | Physici /Medic | | 1. Decedent's Name (First, Middle, L Ralph Evg | ene G | idd.n | 95 | 5r. | | | F | Date of Dear Month | 200 | | 3. Time of Death |
| a saint | Examin Funeral | er | | seneral 1 | 1405, 1.46 Age (In vrs. last | birthday | - | unt | cation of De | łrs. Яг | Date of Birth | 1 | ty of Death | place (State or Foreign |
| k | Director | | 220-34-2858 Usual Residence of Decedent | 1 ⊠ M 2□F | 69 | Yrs. | | Days I | Hours Mi | in. 3 | Month, Pay, 127 / 19 |)38 | MI | ntry) |
| | vith the Marylan or 28a-f show be notified at | Director | 10a. State 10b. County 10b. County 10c. Street and Number 7209 Forest Ave. | Arundel | Hane | own or L | ocation 10f. Zip C | ode 210 | 176 | | 1 | 0g. Citizen o | | 1 □ Yes ৡৡৢ No ntry? |
| 15-0036 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | Completed by Funeral | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 15. Decedent's I (Specify only highest g | Year or Dates Education rade completed) | s? □No Korea s: | a. Dece | Was Deceder If Yes, specify 1 Yes 22 edent's Usual of work DO NOT use | nt of Hispa Cuban, I | anic Origin? Mexican, Pu Specify: | | | 14. R | ace - Americack, White, | etc. White |
| nd 212 | e filed withi al Hygiene. I other than vent, the M | Be Comp | Elementary/Secondary (0-12) 10 17. Father's Name (First, Middle, Las | * | r 5+) | | Mechar | nic | | | | Maiden Surna | | ipment |
| Maryla | 12 should be filed w h and Mental Hygie 7 is marked other t traumatic event, th | _0 _0 | Ernest Edward Gi 19a. Informant's Name/Relationship Russell Giddings | (Type. Print) | | | ng Address (S | | f Number or | Rural Ro | | ; City or Tow | n, State, Zij | o Code) |
| Baltimore, Maryland 21215-0036 | Pa Firt: | | 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 4 □ Donation 5 □ Other (Spec | □Removal from Stat | te cem | etery, cre o Cr e | osition (Name ematory or oth ematory | er place) 7 | 1 | Date 5/200 | 08 1 | 20c. Location | ore, N | |
| E E | permit. Departr Importa any Inji | | 23a. Part1. Enter the disease, or co | ~ | ed the death. [| 1 | 2 Ridge | ely A | Ave. A | nnap | olis, | MD 21 | | Approximate |
|) | Physician /Medical Examiner | iner | shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury | a. Pan Due to (or a | as a consequen | | | | | | | | | Interval Between Onset and Death |
| 8/60, | ate be hysicia the bur | dical Examiner | that initiated events resulting in death) Last | CDue to (or a | as a consequen | ce of): | , op | | | | | | | |
| O. Box 6 | death certifi e attending d for use as | Physician/Mec | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2□ No 9 □ Unknown | | 2 ∐Fetal de at time of deat | ath 3 | ⊒Ectopic preg □ Other (spec | | | | | 1 | Date of deliv | ery Day Year |
| rds, F. | requires that the de een signed by the s rould be detached i | | Part II. Other significant conditions Awke Read Fac | contributing to death | but not resulting | g in the u | eks / | se given i | in Part I. | | 23e. Did tot | _ | | he cause of death? bably 4 ☐Unknown |
| II Kecords, | The law ate has b page 2 sh | Completed by | Sepsis Show | k. Arry | them is | iseu | <u>s e, </u> | are. | ا در ای سور | F | 24a. Was a autops perforr 1 Yes | sy | | opsy findings available ompletion of cause of |
| VITA | siclan: certific rector. | Be | 25. Was case referred to medical examiner? | Hospital: | | | | | 6. Place of D | Death (Ch | eck only on | e) | | |
| ō | Phy rat di | tion: To | 1 Yes 2 Mo 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Ir (Month, L | ntient 2 □ ER njury 28 Day Year) | Outpatie b. Time o Injury | | . Injury at Work? | | | | ence 6 Co | | fy) |
| DIVISION | al or Attending s after death. Il Director: After ed in by the fune | Sertification: | 3 Suicide 6 Could not 4 Homicide determine | be 28e. Place of i | njury - At home etc. <i>(Specify)</i> | , farm, st | reet, factory, o | | | | ocation (St City or Town | | mber or Rur | al Route Number, |
| | To the Hospital or A within 24 hours after or To the Funeral Direct completely filled in by | Aedical C | (Check only 2 Medical Exa | Physician: To the best aminer: On the basis and manner | of examination | dge, dea | nvestigation, in | n my opin | ion, death o | ace, and o | t the time, d | ate and place | e, and due t | to the cause(s) |
|) | ₽¥₽5 | Σ | 29b. Signature and title of certifier | he | M | 9 | - 1 | icense ni 746 | 120 | > | 2 | 9d. Date sign Feb. | ned (Month, | 200f |
| ن | Sta | te. | | 10724 L | | ture | | knaj | , Co | dumb | ie | MO | 21 | 044 |
| | Sta Registr | | 31. Date filed (Month Day, Year) FEB 0 5 2 | 008 | L | | 1 | | | | | | ngles. | |

DHMH 17 Rev 1/2001

| | | | For State Registrar | State of M | aryland / De | partment of ertificate of | | _ | enę2 () () 8 | 05127 |
|--------------------|---|---------------|---|--|--------------------------|---|---|---|---|--|
| | | | Decedent's Name (First, Middle, Last) | | | | | 2. Date of Death | . 140. | 3. Time of Death |
| | Physici. | | | HAZEL | MARGARET | GRABLE | | Month February | 5, 2008 | 10:00 P M |
| | /Medic | | 4a. Facility Name (If not institution, give str | | | | or Location of Death | | 4c. County of Death | |
| | Examin | er | St. Catherine's Nur | | | Emmits | | | Frederi | ck |
| | Funeral | | 5. Social Security Number 6. Sex | | ge (In yrs. last birthda | y) If Under 1 Yea | r If Under 24 Hrs. | 8. Date of Birth | | hplace (State or Foreign untry) |
| | Funeral Director | | | 1 2√F | 81 Yrs. | Months Day | s Hours Min. | 8. Date of Birth (Month, Day, Y | 1926 Mar | yland |
| | | | Usual Residence of Decedent | | | | | | | |
| | yland | | 10a. State 10b. County | | 10c. City, Town or | Location | | | | 10d. Inside City Limits |
| | Mar. | 호 | Maryland Frederick | | Thurmont | | | | | 1 Yes 2 No |
| | n the | Director | 10e. Street and Number | | | 10f. Zip Code | | 10g | . Citizen of What Co | untry? |
| | 23a c | | 1 West Moser Road A | pt. 6 | | 2178 | 38 | | U.S.A. | |
| | after deeth with the Marylan or Iteme 23a or 28a-f show | Funeral | 11. Marital Status | . Was Decedent Armed Forces | Ever in U.S. 1 | 3. Was Decedent of | Hispanic Origin? (Spiban, Mexican, Puert | pecify Yes or No- | 14. Race - Ame Black, White | |
| ٥ | or Ite | | 1 № Never Married 2 Married | Armed Forces? 1 ☐ Yes 2 X If Yes, Give | No | 1 ☐ Yes 2X N | | , | Specify: | |
| 2-0036 | Su P | d by | 3 Widowed 4 Divorced | Year or Dates: | | | | | W | hite |
| ה | n 72 ho "natur edical | Completed | 15. Decedent's Educa (Specify only highest grade | tion com <i>pleted)</i> | (G | cedent's Usual Occ ve kind of work don | e during most of wor | | b. Kind of Business/ | Industry |
| 2 | within 72 ene. then "nai | ם | Elementary/Secondary (0-12) | College (1-4or | 5+) | . DO NOT use retii | rea) | | Sewing F | |
| N | filed v Hygie other t | | 17. Father's Name (First, Middle, Last) | | 56 | amstress | 18 Mother's Nan | ne (First, Middle, Ma | | actory |
| and | be fi | Be | George Grable | | | | Clara K | | idon <i>Samano</i> , | |
| <u></u> | J Men | 10 | 19a. Informant's Name/Relationship (Type | Print) | 10b M | iling Addrage (Stra | | | City or Town, State, 2 | Zin Code) |
| Zaz | d 2 sh h and 7 ie m traum | | Patricia A. Willhid | | | | | | Maryland 2 | |
| | s 1 and f Healt item 2 other | | 20a. Method of Disposition | c / Daug | 20b. Place of Dis | position (Name of | | | oc. Location - City or | |
| altimore, | 0 0 == = | | 1 St Burial 2 ☐ Cremation 3 ☐ Rei | moval from State | cemetery, c | rematory or other p | | | | |
| | | | 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyrieral Service Licersee | | | | Gardens 2/ | | ederick, 1 | |
| Ra | permit. Departimporti | | 21. Signature of Pytheratyservice Licensee | actes! | 1 | ÖBERT E. 15 EAST M | DAILEY & MAIN ST., | SON FUNER THURMONT, | AL HOMES, MD 21788 | P.A. |
| | | | 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one | tions that cause | d the death. Do not | | | | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | 044 | 101/15 | o Re | nal | 1), sea | 18 | Onset and Death |
| | /Medical | | resulting in death) | Due to (or as | s a consequence of | -1 | | 7.3 | | 2 11 |
| | Examiner | | Convertible list and dising | SEU | ere the | 1 Pher | al Vox | cala | J.S.00 | 20 |
| | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as | s a consequence of): | V | | | / | 110412 |
| | cutec nd ransi | Examiner | that initiated events | 11-9 | Rel E | 2136 | u. | | | 401 |
| Ď, | be executed sicien and burial-transit | | resulting in death) Last | Due to (er as | a consequence of): | - | OTO | 0 | \circ | 404D |
| 09/8 | h y | dical | d. | Kon | at ai | lery | 2 /00 | nas - | 3 | 1 0 |
| × | eath certific attanding p for use as t | /Me | IF FEMALE: 23 | c. If yes, outcome | e of pregnancy | | | | 23d. Date of del | livery |
| XOR | attan for u | lan | in the past 12 months? | 1 Live birth | | 3 □Ectopic pregnar 5 □ Other (specify) | псу | | Month | Day Year |
| o | res thet the de signed by the a I be detached f | Physician/Me | 1 ∐ Yes 2 ☑ No 9 ☐ Unknown | 9 Unknown | at time of death | J □ Ottlei (apecity) | | | | |
| <u>a.</u> | thet ed by deta | 핕 | Part II. Other significant conditions conti | ibuting to death I | but not resulting in th | e underlying cause | given in Part I. | 23e. Did toba | icco use contribute to | the cause of death? |
| g | uires sign ld be | d by | Cor man | e Its | ther as | NS-0 | axe | 1 🗀 Yes | : 2021No 3□Pr | robably 4 Unknown |
| ဂ္ဂ | w require been sig should b | ete | Association | 1 11 a | cl acl | à ATI | 01.108 | 1 24a. Was an | 24b. Were au | utopsy findinos available |
| Vital Records, | hes ge 2 | Completed | 113 ana a | 1 /00 | - acti | 0 1100 | -act is | autopsy performe | ed? death? | utopsy findings available completion of cause of |
| _ | icien: Th certificate rector, pag | | OF Mean age and an ending! | | | | | | No 1 □ Yes | 2 □ No |
| \rightarrow | sicien certii recto | Be | 25. Was case referred to medical examiner? | spital: | | | 7th an | th (Check only one) | | -4-1 |
| ō | Phys rahis raldi | 5 | 1 ☐ Yes 2) No | 28a. Date of Inj | | tient 3 DOA | 4 V Hursing F | 28d. Describe how | ice 6 Other (Spe vinjury occurred | cny) |
| 0 | ding F. th. After funera | ţ | 1 Natural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Inj (Month, Da | ay Year) Inju | | Vork? □Yes 2□No | | | |
| Division of | l or Attendil after death. Director: A I in by the fu | fica | 3 Suicide 6 Could not be | 28e. Place of In | njury - At home, farm, | street, factory, offic | ce · | | et and Number or Ri | ural Route Number, |
| á | s after s after of Dire | Certification | 4 Homicide determined | building, e | etc. (Specify) | | | City or Town, | State) | |
| | To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page | edical | 29a. Certifier (Check only one) Certifying Physi 2 Medical Examine | cian: To the bes er: On the basis and manner s | of examination and/o | eath occurred at the r investigation, in m | time, date and place y opinion, death occu | e, and due to the cau arred at the time, dat | use(s) and manner as te and place, and due | s stated. e to the cause(s) |
| | To the within To the | Me | 29b. Sign sture and title of certifier | 0 | 1. 60 | 72 2 2 c. Lice | ense number | 29 | d. Date signed (Mont | th, Day, Year) |
| , |) (| | 30. Name and address of persen who con | poleted cause of | death (Item 22a) Fr | ne Print\ | 1044 | 121-12 | 3 co. Gi | raws/ |
| | 4 | | Bouta 1: K | 2 Du | PER- A | RILE | 12 NOE | mung | Blows | m)21) |
| | Sta Regist | ate | ST. Date filed (Morlth, Day, Year) FEB 7 20 |)08 32. R | rar's Signature | South | | , | 0 | |
| 7 | negist | all | | 1 | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. UUR Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Madge Gott February 2008 0854 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner E1kton Cecil Union Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 💢 F Director 404-42-5276 March 2, Kentucky Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 X Yes 2 □ No Funeral Directo E1kton Maryland Ceci1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or Item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must be 119 Maffitt Street, Apartment 4 21921 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Custodian Public School District 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ida Collins William Clarence Jackson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if item 27 is any injury or other tra Gloris J. Deel/Daughter 101 Ontario Court, North East, MD 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February 1 M Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Flatlick, KY Jackson Cemetery 16, 2008 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licenses 103 W. Stockton Street, Elkton, MD 21921 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 9401 /Medical Due to (or as a consequence of): Examiner COPO Euphyseusto. Sequentially list conditions, ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 □Ectopic pregnancy Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2√ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 29a. Certifier 1 🗗 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hou To the Fune completely fi

State Registrar

Alfred 31. Date filed (Month, Day, Year) FEB 21

29b. Signature and title of certifier

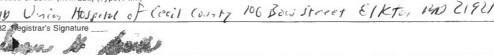
E / CTuy

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008



and manner stated



29c. License number

D0055190

29d. Date signed (Month, Day, Year)

February 11, 2008

Certificate of Death

3. Time of Death 9:30A M

9. Birthplace (State or Foreign Country)
NEW JERSEY

U. S. A.

Black White etc.

Specify:

14 Bace - American Indian

WHITE

10d. Inside City Limits

1 □Yes 2XXX

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FEBRUARY 12, 2008 GLADSON SMITH LOUISE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner CHARLES LA PUATA MEDICAL CENTER 8. Date of Birth (Month, Day, Year) OCT . 22, 1922 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days 1 □ M 2 💢 F 85 Director 100-16-3742 Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at Director WALDORF CHARLES 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in 20602 70 VILLAGE STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo \$ 3 ☐ Widowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene, Important: if item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. ADMINISTRATIVE ASSISTANT SCHOOL SYSTEM 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EARL SMITH ပ 19a. Informant's Name/Relationship (Type. Print) JUDY GLADSON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FEBRUARY 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician NEWMONIER /Medical Due to (or as a consequence of Examiner DURNOUS O MYCRUSCLANUSI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Z No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 24a. Was an ate has l certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 💢 No 17 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27 Manner of Death 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.
neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 5 To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mamer stated. 29b. Signature and title of certifier 29c. License number D20629

MARY LOUISE BUDD 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1200 APPLE VALLEY RD.ACCOKEE, MD 20607 20c. Location - City or Town, State METROPOLITAN CR. 13, 2000 ALEASURE 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. 5635 WASHINGTON AVE., LAPLATA, MD 20646 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♠ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 22 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 11345 PEMBROOKE SQUARE SUITE 103 WALDORF, MD. **ORIGINAL**

Box 68760,

P.0.

Division or Vital Records,

State Registrar GEORGE WATHEN 31. Date filed (Month, Day, Year) FEB 2.1



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 31 Month **Physician** Brenda L. Harris January 2008 9:55 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 2 1948 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days Min 1 □ M 2 □ 217-52-3402 59 Yrs. Marviand Director Usual Residence of Decedent 10c. City. Town or Location show 10b. County 10d. Inside City Limits ns 23a or 28a-f shor must be notified at Maryland Anne Arundel Annapolis Y☐Yes 2☐No 10f. Zip Code 10g. Citizen of What Country? 1009 Queen Annes Lace Way 21401 USA items 23a Funeral death permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural": or incompany injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐No Specify. ģ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) General Elementary/Secondary (0-12) College (1-4or 5+) 12th 6yrs Auditor Accounting Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elliott Lindsey Lovie Higgins ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21401 Curtis Harris Jr(Husband) 1009 Queen Annes Lace Wav Annapolis, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Maryland Veteran 2-6-08 Crownsville, Md. 4 Donation 5 Dother (Specify) And Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 ear M00483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** CANCER YNS disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed and -trans Due to (or as a consequence of) attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) P.O. ed by the a 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should I Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate Division or Vital Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient P 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Injury (Month, Day Year) 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident To the Hospital or Attenct within 24 hours after death To the Funeral Director: the 1 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion death account of the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1008115 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

STANLEY

32. Project Signature

BROTE BOTE RO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 08 **2**032 M MAE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HESTER TOWN ent If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Social Security Numbe 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗶 F 98 MD 1/27/1910 219-07-6836 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County r 28a-f show notified at 1 XYes 2 No Funeral Director ROCK HALL MD KENT 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with inent of Health and Mental Hygiene. An It Item 27 is marked other than "natural", or items 23a or item yor other traumatic event, the Medical Examiner must be nury or other traumatic event, the Medical Examiner must be no 21314 HAVEN RD. 21661 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐ Yes 2**X** No Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: WHITE Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING **SEAMSTRESS** 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DAVID C. ASHLEY CLARA M. ASHLEY 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PATRICIA L. LEWIS/DAUGHTER PO BOX 535 ROCK HALL, MD 21661 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 2/13/2008 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA 130 SPEER RD. CHESTERTOWN, MD 21620 23a, 7an1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, proock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ongestive **Physician** disease or condition resulting in death) /Medical Examiner atheros de Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 1□ Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

5 ms

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

S2. Registrar's Signature

FEB 1 3 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Willen, MD



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Amendment#10e 1- State Registrar Kent Co., MS, 02/12/08 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day **Physician** 650 AM MESSENER 2000 FERRY ARGARET /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner KENT HERON POINT HESTERTOWN If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2**X**1F Yrs. 206 18 1971 JAN 30, 1915 VIZGINA WEST Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State show 1 Yes 2 □ No KENT 28a-f sh notified CHESTERTOWN MD **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 01 East Campus Avenue "natural", or items 23a or edical Examiner must be U.S.A. 21620 Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: WHITE Specify: þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 7 is marked other than "natu traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1,-4or 5+) LIFE INSHRANCE PRIVATE 12 ECRETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CATHERINE MARY IONKIN ၉ C'LEMENT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 any injury or other tr ROCC C HACC MD 2

20c. Location - City or Town, State ANN MCHUGH 22519 CROUCHS LANS 21661 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State CHESAPEAKE CREMATING FEB 10, 2008 CHESTER, MD

22. Name and Address of Hollity AMS, JR FUNERAL DIRECTOR

MARYIN V WILLIAMS, JR FUNERAL DIRECTOR 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 205 GREWN HERON WAY CHESTERTOWN, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 54ears 412heiner 5 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an s certificate has b irector, page 2 sl autopsy performed 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 27. Marmer of D ath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

ne Funeral Director: A pletely filled in by the fi 2 Accident 6 □Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hou

To the Fune
completely fi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lestaton Md allase Washington Hol Som K. 516 Koss InD. 32. Registar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

| | | | 1 - For State Registrar | State of N | Marylar | nd / Depa | artme rtifica | nt of H | lealth a | ind M | | Reg. N | | 8 0 | | |
|---------------------|--|-----------------------------|--|---|---|------------------------------|--------------------------|--------------------------|--|-----------|-----------------------------------|--------------------|-------------|--------------|----------------------------------|----------------------|
| | Physic | ian | Decedent's Name (First, Middle, L. | , | | | | | | | 2. Date of 0 Month | D | ay | Year | 3. Time of | |
| W | /Medi | cal | Catherine A. H 4a. Facility Name (If not institution, gi | | el. | | 4h Cih | Taura a | Location o | | ebru | | c. County | | 4:50 | рм |
| | Exami | ner | Charles County | | | chah | | LaPl | | r Death | | 4 | | rles | | |
| | Funeral | | | | | last birthday) | If Unde | er 1 Year | If Under 2 | | 8. Date of E | Birth | | | lace (State o | or Foreign |
| | Director | | 220-40-6251 | 1 □ M 2 □ X F | 65 | Yrs. | Months | Days | Hours | Min. | 8. Date of E (Month, I Dec. | 18, 1 | 942 | Was | hingt | on D |
| | pg . | | Usual Residence of Decedent 10a. State 10b. County | | 100 Ci | ty. Town or Lo | anting. | | | | | | | | 04 1:4- 0: | |
| | ehow | 5 | | - | | | | | | | | | | ' | 0d. Inside Ci 1 🗌 Yes | |
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| | death with the Maryland ma 23a or 28a-f ehow mait be notified at | 0 | 5695 New Cut R | bso. | | | 101. 2 | 206 | 58 | | | | S.A | | iu y : | |
| | ma 2 | by Funeral Director | 11. Marital Status | 12. Was Deceder | t Ever in U | l.S. 13. | Was Deci | | | gin? (Spe | ecify Yes or I Rican, etc.) | | 14. Rac | e - Americ | | |
| 9 | or Its | Ē | 1 Never Married 2 Married | Armed Forces 1 Yes 2 If Yes, Give | | | | | in, Mexican Specify: | , Puerto | Hican, etc.) | | | k, White, | | |
| 003 | nours ural'. | d b | 3 ☐ Widowed 4 ☐ Divorced | Year or Dates | : | | 1 1 1 62 | 2 4 1 140 | зр о спу. | | | | Specify | " Wh | ite | |
| 5- | "nate | Completed | 15. Decedent's E (Specify only highest gi | | | 16a. Dece | kind of w | ual Occupa ork done o | ation <i>duri</i> n <i>g</i> most () | of work | in <i>g</i> | 16b. | Kind of Bu | usiness/Ind | dustry | |
| 12 | withi ene. than | E D | Elementary/Secondary (0-12) | College (1-4o | r 5+) | | emal | | , | | | He | er Ho | ome | | |
| 0 | Hygi other | Be Co | 17. Father's Name (First, Middle, Las | t) | | 11011 | i Cilia. | | 18. Mothe | r's Name | e (First, Midd | | | | | |
| lan | Aenta Aenta rked | To B | Samuel E. Syd | lnor | | | | | Les | lie | A. M | onto | jome: | ry | | |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a or 28a-1 ehow any injury or other traumatic event, Ita Medical Exercitar must be notified at ance. | 10 | 19a. Informant's Name/Relationship | (Type, Print) | | 19b. Mailii | ng Addres | s (Street a | and Numbe | r or Rura | al Route Num | nber, City | or Town, | State, Zip | Code) | |
| 2,5 | and ealth m 27 her tr | | Luther R. Huff | man Hus | | 1 5695 | | | | | | | | | | 58 |
| Baltimore, | If ite | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [| ☐Removal from Stat | e 205. F | Place of Disponentery, crei | natory or | ime of other plac | ^{e)} Feb | .8. | 2008 | 20c. l | _ocation - | City or To | wn, State | |
| Ħ | t. Pa rtmen rtant: njury | | 4 Donation 5 Dother (Special | | Tr | | | | | | ens | Wa | ldo | rf, | Maryl | .and |
| Ba | Depa Impo eny li | | 21. Signature of Funeral Service Lice | ·/ | 10066 | Q W | ill | iams | ss of Facility Fund | era: | l Hom | e, E | .A. | | | No. of the No. |
| | | | 23a. Part1. Enter the discase, or con | nplications that cause | ed the deat | th. Do not ent | 270 er the mo | Haw de of dyin | thori | ne I | Rd., or respiratory | Indi | an | Head | Approximate Interval Bets | 2064 e |
| - | Physician | Ŋ, | shock, or healt fail re. List only Immediate Cause (Final | | | dage | co | PD | | | | | | 4 | Onset and (| Death |
| | /Medical | | disease or condition resulting in death) | a. Due to (or a | | • | | • | | | | | | - | Year. | ١ . |
| п | Examiner | | Sequentially list conditions | b | | | | | | | | | | | | |
| | D # | ner | Sequentially list conditions, any leaf of our rectate cause. Enter Underlying Cause (Disease or injury | Due to (or a | s a cons | uanda of): | | | | | | | | | | |
| | The law requires that the death certificate be executed ate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit | Examiner | that initiated events resulting in death) Last | c. Due to (or a | s a consec | uence of): | _ | | | | _ | | | | | |
| 8760, | be ey icien buria | alE | | 000 10 (01 0 | 3 4 6011364 | derice or). | | | | | | | | | | |
| 687 | ficate physis the | edical | | _ d. | | | | | | | | | | | | |
| Box | eath certific attending p | Physician/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcom | | | | | | | | | 23d. Da | e of delive | irv | |
| | death e atte | icia | in the past 12 months? 1 ☐ Yes 2 ☑ No | 1□Live birth 4□Pregnant | | | "Ectopic p] Other (s | pecify) | | | | | Mo | | _ | r'ear |
| P.0 | that the de led by the a detached t | hys | 9 □ Unknown | 9LJ Unknown | | | | | | | | | | | | |
| | res tha igned be det | þ | Part II. Other significant conditions Preumenta | | | | | | | nu | | | _ | | e cause of d | |
| ord | w requir been si should | ted | 7 // (5/1/4/4/4/4/4/4/4/4/4/4/4/4/4/4/4/4/4/4/ | ,, | | · , p | NED | MEG | - 7-7 | | 1(| DYes 2 | 2 ∐ No | 3∐Prob | ably 4 🗀 | Inknown |
| of Vital Records, | e law hes t | Completed | | | | | _ | | | | | topsy | , p | prior to cor | psy findings a npletion of ca | available ause of |
| a | | | 25.14 | The second section of the second | | | | | | | 1 ☐ Yes | formed? | | death? | 2 🗆 No | |
| Χ | sicial | o Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No | Hospital: | | EB/O | | OA Othe | | | Check onl | | | | | - |
| of | Attending Physician: r death. ector: After this certifics by the funeral director. | $ \mathbf{P} _{\mathbb{R}}$ | 27. Manner of Deam | 28a. Date of In (Month, D | | ER/Outpatier 28b. Time of | | 28c. Injury Work | 4 JU Nur | | me 5 ☐ Re 28d. Describ | | | | /) | |
| ion | death. ctor: After the funer | atio | 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation | | ay Year) | Injury | М | | k? Yes 2∐N | 10 | | | | | | |
| Division | or Attendation of the Director: | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | 28e. Place of II | njury - At he | ome, farm, str | eet, facto | ry, office | | | 28f. Location | (Street a | ind Numb | er or Rura | l Route Num | ber, |
| | ospital or A hours after uneral Dire | | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | | <i></i> | om, ota | | | | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. | edical | (Check only 2 Medical Exa | hysician: To the bes miner: On the basis | of examina | wledge, death | occurred | d at the tim | ne, date and pinion, deat | lace a | and due to the | e causele, date ar | s) and ma | nner as st | ated. the cause(s |) |
| | ithin 2 on the | Med | one) 29b. Signature and title of certifier | and manner s | itateo. | | | c. License | | | | | | d (Month, i | | |
| | F 3 F 8 | | | R. SINDH Sudward | | , , | | | 0616 | 14 | | | | 1200 | | |
| (| | | 30. Name and address of person who | | | n 23a) (Tvne | Print) | - | | | | | | | | |
| 1 | B8 | | 6 POST OFFICE | E RD., u | ALD | ORFI | M.D | | | W-9. | | | | | | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) FEB 0 6 | 32. Reds | trar's Signa | ture | bout | 6 | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Montal Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav ELIZABETH L. HARRISON 4c. County of Deatl 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Months Days 1 □ M 2**XX** Hours Min 215-18-0376 86 AUG 22,1921 **GEORGIA** Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No MD TALBOT SHERWOOD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7662 SHERWOOD ROAD 21665 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give 2 **X**No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 【No Specify. Specify: WHITE 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) GEORGE W. SAUNDERS BERTHA McGALLIARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RONALD WISECUP/PER REP. 30882 DRIFTWOOD DR., LAGUNA BEACH, CA 92651 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 2/3/2008 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 C.F.SP. Jasoph USTROWSK, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myelogenous teukenner Acule Days disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, any transition of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of). If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show a or 28a-f sh t be notified

23a

or items

the Medical E

Department of Health and Mental Hy Important: If item 27 is marked othn any Injury or other traumatic event.

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural"; or ite

Baltimore, Maryland 21215-0036

must

Director

Funeral

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Completed

Be

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death with the Maryland

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certificate

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After

Director:

in 24 hours the Funeral Dire

Medical

Exami Physician/Medical þ Completed Be Certification: To

physician a attending property for use as signed t page 2 dire funeral

within 2. To the I 2+4

Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760.

State Registrar

IF FEMALE: 23b. Was decedent pregnant 9 Unknown

1 Tyes

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

25. Was case referred to medica examiner? 200 No 27. Manner of Death

5 ☐ Pending investigation 6 Could not be

Hospital: 1 🔀 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 **X**No

29b. Signature and title of certifier Ramin

MD

D66441

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year) February 2 2008

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kolli Ramehr Street, Easton MD 2195 washington

and manner stated.

31. Date filed (Month, Day, Year) FEB 04 2008 egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 259 cm PATRICIA ANN HOKE February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat **Examiner** Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 □ F 20, 1949 **Director** 218-50-4767 58 Nov. Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County th and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland | Frederick Thurmont 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 12604 Catoctin Furnace Road 21788 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 □ Yes 2**X** No Specify: ð 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Folder Shoe Factory 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lloyd Eugene Hoke Margaret Viola Anders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathy J. Wastler / Daughter 12604 Catoctin Furnace Road, Thurmont, MD 21788 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 □ Other (Specify) Prospect Ch. Cem. 2/8/08 Lewistown, Maryland ROBERT E. DAILEY & SON, FUNERAL HOMES, P.A. uperal Service Licensee alle 615 EAST MAIN STREET, THURMONT, MD 21788 23a. Part1. Enter the disease, or compt. Ilions that covered the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only to cause on e.ch line. Approximate Interval Between Onset and Death Immediate Cause (Final HYPOLIC RESPIRATORY Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMOTHORAY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine The law requires that the death certificate be executed END STAME RENOW FAILURE attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, HEPATORENITE SYNDROME Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d, Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? 4 □ Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I_{λ} 23e. Did tobacco use contribute to the cause of death? 2 NEUMONIA ANEMIL Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10062006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. ANTIETAM ST. HAGERTOWN 251 An-11-160 DW.D WIRSON 31. Date filed (Month, Day, Year) State 2008

Registrar

| /legan Julie Ha | | 1- For State | State | of Maryland | | artment of <i>rtificate of</i> | | and | Menta | ıl Hygiene | | 20016 | 6517 | 2 / |
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| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Memilal Hygiene. Important: If filem 27 is marked other than "matural", or items 23a or 28a-f show lujury or other traumatic event, the Medical Examiner must be notified at once. | ā | 10680 Po | pes C | reek Roa | d | | 206 | 32 | | | | U. S. | Α. | |
| with with be no | Funeral Director | 11. Marital Status | | 12. Was Deceder | | | | | | ? (Specify Yes | | 14. Race - Ar | merican Indian, Blad | ck, |
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| after al", o | by F | 3 Widowed | 4 Divorce | If Yes, Give Year | A. | 1 | Yes 2 X | No s | specify: | | | Specify: | White | |
| ours | D D | 15. Decedent's Educa | tion (Specify o | only highest grade co | mpleted) | | | | | d of work done | - 1 | 6b. Kind of Busine | ess/Industry | |
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| 036 ithin ne. | m d | 12 | | | | Homem | aker | | | | , | At Home | | |
| 5-0 ed w fygie other | Completed | 17. Father's Name (Firs | st, Middle, Las | 1) | - | | | 18. | .Mother's | Name (First, Mic | ldie, Ma | iden Surname) | | |
| 21, be fill rtal F rked | Be | Julian L | loyd H | łayden | | | | | Joy | ce Ann | Fu | nk | | |
| 21 Duld I Mer man | 2 | 19a. Informant's Name | Relationship (| Type, Print) | | 19b. Mailing | Address (| | | | | er, City or Town, S | tate, Zip Code) | |
| AD 2 sho 27 is 17 is | | Julian L | . Hayo | den/Fath | er | 1068 | 0 Pop | es | Cree | ek Rd. | Fa | ulkner, | MD 2063 | 32 |
| e, l and Healt item item | | 20a. Method of Disposi | | | | Place of Dispos | ition (Name | of ceme | tегу, | Date | | 20c. Location - City | | |
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| ti. Partmen | | 4 Donation 5 21. Signature of Funera | | | ILL | TUITY | Mem . G | ran | S. | 16,2008 | 3 | Waldor | f,Maryla | and |
| Ba Perm Depa Impo | | no de la | 3 Service Lice | isee) | 1 | 22.1 | o = | u ess 01 | Facility I | Raymond | d Fu | unl.Ser | vice,P. | Α. |
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| Box 6876 e death certificate the attending phy ed for use as the | Physician/N | 23b. Was decedent preg past 12 months? | gnant in the | 1 Live birth | | | tal death | 3 | Ectopic p | regnancy | | Month | Day Y | ear |
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| Division of Vital Records, P.O. Is an art data the rate data that the law requires that the law requires that the law factor: After this certificate has been signed by the led in by the funeral director, page 2 should be detached. | ğ | Part II. Other significa | nt conditions | contributing to dea | ith but not r | resulting in the t | nderlying ca | iuse give | en in Part | | _ | | e to the cause of de | |
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| ord v req shou | Completed | | | | | | | | | | Was an autopsy | | e autopsy findings a to completion of ca | |
| ecc he lav te ha | Ĕ | | - | | | | | | | | perform Yes 2 | | | No |
| r: T | ŭ | 25. Was case referred | to medical | | | | 26.1 | Place of | Death (C | heck only one) | 100 2 | | 103 2 | 110 |
| /ita sicial is cer | Be | examiner? | _ | Hospital: | ent 2 | ER/Outpatient | | Ot | her: | Nursing Home | 5 R | esidence 6 🗸 O | ther: Scane | |
| of V | P | 1 ✓ Yes 2 27. Manner of Death | No | 28a. Date of In | | 28b. Time of I | | | at Work? | | (command) | w injury occurred | Tarior . Cooling | |
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| Spits hours nera | ဗ | 4 Homicide 29a. Certifier 1 Cer | - Colonina | (Specify) | resid | dence | | | | Fau | Ikne | er, Maryl | and | |
| n 24 re Fu | g | (Uneck only | | ian: To the best of r | - | - | | | | | | | | |
| Division of Vital Records, P.O. Box 6876 within 24 hours after death certificate within 24 hours after death or his certificate to the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the l | Medical | 2 👿 | | r:On the basis of ex- and manner stated | | and/or investigat | | | | irea at the time, | | | | , |
| | Σ | 29b. Signature and title | of certifier | 11 | | | 29c. Li | icense n | umber | | 1 | 29d. Date signed (| (Month, Day, Year) | |
| | | | 1 MM | . 1/// | | | C | D.C.M. | E. | | | February 12, 2 | 2008 | |
| | 1 | 30. Name and address | f person who | completed cause of | death (item | n 23a) | | | | | | | | |
| | - 1 | Jack Titus MD. | | Chief Medical E | , | , | n Street, | Baltim | nore, M | D 21201 | | | | |
| S | ate | 31. Date filed (Month, D | ay, Year) | 32. Registr | ar's Signati | ure | | | | | | | | |
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| | | 1. Decedent's Name | (First, Middl | e, Last) | | | | | | | 2. Date of D | | | | 3. Time o | f Death | | |
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| edica | | | | | (mhor) | | | Ib City Town | or Locatio | n of Death | TCDIGE | _ | | y of Death | | | | |
| mine | | 4a. Facility Name (If not institution, give street and number) | | | | | | 4b. City, Town, or Location of Death | | | | | | • | | | | |
| | | 832 Bell Manor Road | | | | I A I- I-46 al | | Conowingo If Under 1 Year If Under 24 Hrs. 8 | | | To 5 1: (5) | | Ce | cil | 1 (01-1- | | | |
| ral | | 5. Social Security Number 6. Sex | | | 7. Age (In y | 7. Age (In yrs. last birthday) | | Months Days | | | 8. Date of Bi (Month, D | irth <i>ay, Y</i> ea | r) | 9. Birth | nplace (State untry) | or Foreign | | |
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| | 5 | 11. Marital Status | | 12. Was Dec Armed F ried 1 ☐ Yes | 10.0. | If Y | is Decedent <i>o</i> f 'es, specify Cu | ban, Mexic | can, Puerto | | ack, White | | | | | | | |
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| | | 17. Father's Name (| First, Middle, | Last) | | | | | 18. Moi | ther's Nam | e (First, Middle | e, Maide | en Surna | me) | | | | |
| | 2 . | Adolph | us Joh | nson | | | | Ida Hart | | | | | | | | | | |
| | 1 | 19a. Informant's Na | | | ailing . | ling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | | | |
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| | 4 | | | son/Wife | Tank | | 2 Bell Manor Road, Conowingo, MD 21918 Date 200 Location - City or Town, St. | | | | | | | | | | | |
| | | 20a. Method of Dispo 1 ☑ Burial 2 ☐ | cemetery, | e of Disposition (Name of etery, crematory or other place) | | | | | 20c. Location - City or Town, State | | | | | | | | | |
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| oj | Ī | 21 Signature of Funeral Service Licensee 22. Name and Address of Facility | | | | | | | | | | | | | | | | |
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| | | IF FEMALE: | | | | | | | | | | | | | | | | |
| | _ | 23b. Was decedent | | 23c. If yes, ou 1☐Live | utcome pf pre- birth 2 F | | 3□E | ctopic pregnan | | 23d. Date of delivery | | | Vana | | | | | |
| 3 | 3 | in the past 12 r 1 ☐ Yes 2 ☐ | | 4□Preg | nant at time of | | | Other (specify) | | | | Month | | | Day Year | | | |
| | 2 | 9 ☐ Unknown | | 9□Unki | nown | | | | | | | | | | | | | |
| ā | | Part II. Other signifi | cant conditi | ions contributing to | death but not i | resulting in th | e und | erlying cause g | iven in Pa | rt I. | 23e. Did | tobacco | o use cor | ntribute to | the cause of | death? | | |
| 1 | 2 | CONGES | TIVE. | HEAR | | 1 | | | | | ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown | | | | | | | |
| | | | | 110-11 | 11110 | / | | | | | | | 4 | | | | | |
| 1 2 | 1 | | | | | | | | | | 24a. Wa aut | opsv | | prior to c | topsy findings completion of | s available cause of | | |
| | 5 | | | | | | | | | | per 1□ Yes | formed? 2 X I | No No | death? 1 ☐ Yes | 2 □ No | | | |
| 25. Was case referred to medical 26. Place of Death (Check only) | | | | | | | | | | | | | | | | | | |
| | | examiner? | lo. | Hospital: | Unpatient 2 | □ EB/Outos | tiont | 30004 0 | thor: | | | | 6 DO | thor (Cno. | nife d | | | |
| ŀ | - | 1 Impatient 2 Envoupalient 3 DOA 4 Nursing Home 518 Hesidence 6 Dotner (Specify) | | | | | | | | | | | | | | | | |
| | 5 | 1 Natural | 5 Pendir | ng (Mo | nth, Day Year | | | 28c. Inj W | | | 200, 2000,00 | | ,,, | | | | | |
| 27. Manner of I ath Natural S Pending investigation S Suicide Homicide 28a. Date of Injury (Month, Day Year) 28b. Place of injury - At hom building, etc. (Specify) 29a. Certifier (Check only one) 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and manner stated. | | | | | | | | M 1 Yes 2 No | | | | | | ion (Street and Number or Rural Route Number, | | | | |
| 9 | | 4 ☐ Homicide | detern | ningd 266, Flac | e of injury - A ding, etc. <i>(Sp</i> e | t home, farm, e <i>cify)</i> | stree | t, factory, office | 9 | | 28f. Location City or To | (Street own, Sta | and Num ate) | iber or Ru | ıral Route Nu | mber, | | |
| ا ا | 5 | | | | | | | | | | | | | | | | | |
| | ة ق | 29a. Certifier (Check only (C | | | | | | | | | | | | | | | | |
| = | | (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | | | | | |
| | | | | | | | | 29c. License number | | | | | 29d. Date signed (Month, Day, Year) | | | | | |
| ' | | | | | DOMIL 2-12 DISTORNE | | | | | LAND | | | | | | | | |
| | | | m | | 00066525 | | | | | 74/2008 | | | | | | | | |
| | | 30. Name and address | ess of person | who completed cau | ise of death (I | tem 23a) (Ty | pe, Pr | int) | | Der . | | . / . 0 | | 4.5% | Juli. | | | |
| | | KOBEK | (W | W. M | 2 | 51 E. | M | AINS | 1 | 4121 | NO | NVC | 11 | 10 | 4 111 | | | |
| State | | 31. Date filed (Mont | | 2000 | Registrar's Si | gnature | 2.2 | Y . | | | | | | (| , , | | | |
| istra | | FE | 5 7 | 2008 | W S | J. 60 | 34 | | | | | | | | | | | |

Registrar

amended 2/11/08 item #6 & 19A/wichd/map

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Physician /Medical Examiner Funeral Director | 1. Decedent's Name (First, Middle, Last) Ni IIIan J. Jarm 4a. Facility Name (If not institution, give s | on | | | | O Date of Dag | 41. | | | |
|--|--|---|-------------------|--|--|---------------------------------------|---|---|--|--|
| Examiner funeral Director | | | | | | 2. Date of Dea Month | Day OZ | 2608 | | |
| Director | 101 | ne | | 4b. City, Town, or Berty | 7 | | 6 | ounty of Death | ter | |
| | 5. Social Security Number 6. Sex 15-36-0756 1X | M 2□F 7. Age (In yrs. las | | Months Days | If Under 24 Hrs Hours Min. | | 39 | COL | place (State or Foreintry) YUBND | |
| 2 . | 10a. State 10b. County Md WORCE | | Town or Local | / | | | 10a Citiza | n of What Cou | 10d. Inside City Limi Yes 2□N | |
| Sa or 2 at be n | 10e. Street and Number 104 OAK Lai | | 10f. Zip Code 2/8 | 7// | | SA | 211d y 2 | | | |
| al', or items 23a or 28a-f si Exercite final be rediffed by Funeral Director | | Was Decedent Ever in U.S. Armed Forces? MYes 2 □ No I/Yes, Give Year or Dates: | j | Vas Decedent of Hi Yes, specify Cubar Yes 20 No | ispanic Origin? (S n, Mexican, Puer Specify: | Specify Yes or No- to Rican, etc.) | | Race - Amer Black, White pecify: Bl | , etc. | |
| than " | 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) | ade completed) (Giv life. | | ent's Usual Occupa kind of work done of OO NOT use retired - emp loye | king | | and scaping | | | |
| even Be | 17. Father's Name (First, Middle, Last) Franklin MoL | | 1 ON | | 18. Mother's Na ELLA | me (First, Middle, | | SMAC | | |
| n 27 is muser traumi | 19a. Informant's Name/Relationship (Ty) Teanette John | son-wife | 532 | W. Bro | ok hav | | Ap | TOWBIFUELK K/9 ation - City or | haven, PA PA 190 Town, State | |
| artment of the | 20a. Method of Disposition 1 Surial 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. Signature of Funeral Server Licence | emoval from State Md | Vetera | intion (Name of natory or other place) 705 Ceme? Name and Address | tery 2- | 11-08 | Beu | lah, r | | |
| de E E E | M | auto | | | erac H | ome | 2 | Alish | ury md 2 | |
| nysician Medical xaminer | 23a. Part1. Enter the disease, or complishock, or hear lautere. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying | Due to (or as a conseque | ence of): | ncer | | | | | Onset and Death | |
| tte has been signed by the attending physicien and page 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner | <u>a</u> | | | | | | | | | |
| d by the attending pretached for use as the Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal o 4 □ Pregnant at time of dea 9 □ Unknown | death 3 | Ectopic pregnancy Other (specify) | , | | 23d. Date of delivery Month Day Year | | | |
| n signed by | Part II. Other significant conditions con | en in Part I. | | | vacco use contribute to the cause of death? us 2 No 3 Probably 4 Wunkno | | | | | |
| rifficate has been siter, page 2 should | | | | | | 24a. Was auto perfo 1 ☐ Yes | | prior to death? | itopsy findings avail completion of cause 2 No | |
| s certific director, o Be (| 25. Was case referred to medical examiner? | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H | | | | | | | Other (Specify) | |
| 결을 누가 | 1 Yes 2 No 27. Manner of leath 1 Natural 5 Pending 2 Accident investigation | | | | | | | | ,, | |
| 2 | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At hor building, etc. (Specify) | me, farm, str | eet, factory, office | | 28f. Location (City or To | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| Funer Funer tely fill | 29a. Certifier (Check only one) 29 Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | |
| To the comple | 29b. Signature and title of certifier Manual Manua | ompleted cause of death (Item | | DS8 | 755 | | 29d. Date | signed (Mont | 11, Day, Year) 2008 | |
| Ly | 30. Name and address of person who co Glem K. Hvzad 31. Date filed (Month, Day, Year) | empleted cause of death (Item | 23a) (Type. | Print) | nive | Berlin | , m | 0210 | 511 | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 5 per fh, g8/6,02/20/08dhb.
Reg. No.

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10, PM WOODROW JONES Jan. 2008 9:00 JOSEPH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5/10/1922 Birthplace (State or Foreign Country) **Funeral** Months Hours Days 85 Maryland Director Terminesidence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐Yes 2 No Funeral Director MD. Carroll Hampstead 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3820 Sunnyfield Court 21074 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Be Completed by White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) U.S. Dept. of Elementary/Secondary (0-12) College (1-4or 5+) Loan Administrator Agriculture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Arthur Charles မ Jones Allie Osborne 19a. Informant's Name/Relationship (Type. Print(Niece) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21050 Patricia A. Wallace 1316 W. Jarrettsville Rd. Forest Hill, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Carroll Cremation 1/14/2008 Hampstead, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Solvice Vicensee 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Meretine /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Siecaes of it Juny that initiated events resulting in death) Last Due to (or as a consequence of). Examiner sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No sate has been signed by the page 2 should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an certificate has autopsy performe 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral director. 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No ·2 ☐ Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5BL 11, D3229 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIS W. MALPHA.
32. Figistrar's Signature Biloir ma 5. Dunn 31. Date filed (Month) The Year) State 2008

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 12:35 PM Helen May Keefer 8. February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Washington Williamsport Homewood Retirement Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 ☐ M 2 💢 F 93 Maryland Director 219-20-3632 June 19, 1914 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Williamsport Maryland Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21795 USA Cottage 74 16505 Virginia Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" -- any Injury or other fraumatic. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Manufacturing Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bessie Telitha Bricker John Calvin Sword 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11807 Jasmine Court Hagerstown, MD 21740 Tina Farley - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Paul's Cemetery 02-12-2008 | Clear Spring, Maryland 22. Name and Address of Facility Osborne Funeral Home, P.A. 21. Signature of Funeral Service Lice Majall S.Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediat Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be exect Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical the IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 200 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 3□ DOA Will Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Certification: 1 Natural 2 Accident Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of ce WH-2

State Registrar

12

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 3:40 P M 3. February Klepper 2008 Edna Mae /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Harbour Health Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9/21/1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖬 F MaryTand 77 215-28-6421 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County an "natural", or items 23a or 28a-f show Medica Examiner must be notified at 1 Tyles 2 □ No Director Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1212 Tyler Avenue 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 2 3 ☐ Widowed 4 💢 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) 12th College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be (unknown) Nettie Fishpaw 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 831 Hillside Ave., Edgewater, MD 21037 Carol E. Southwick/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/5/08 Kalas Crematory Edgewater, MD 4 □ Donation 5 □ Other (Specify) Service Licensee 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each flipe. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** aedia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any conditions in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 performed 2 1 N funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, P.O. Box 68760,

State Registrar

(Check only one)

29b. Signature and title

31. Date filed (Month Day)

of certifier

hopra

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D

5 2008

29c. License number

D57028

29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed To the responsible to death.

To the Funeral Director: After this of the Funeral director of the funeral director.

29a. Certifier

(Check only one)

29b. Signature and title of certifier

٤. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LATTID, M.D.

Medical

Registrar

101 COLODIAL Was

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 1033 2008 Lawrence R. Kershner 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death HICHMICO 39486444 If Under 1 Year | If Under 24 Hrs. Social Security Num 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 □ F West Virginia 234-46-8331 Sept. 7, 1931 76 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 1 XYes 2 No Sussex Delmar 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 19940 U.S.A. 603 East State Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 23 Married 1 ☐ Yes 2 ☑ No Korean Specify: white 3 ☐ Widowed 4 ☐ Divorced War 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store District Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna Silver Clarence Kershner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances R. Kershner 603 East State Street 19940 (Wife) Delmar, DE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Delmar, Delaware Crematory of Delmarva 02-05-2008 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Short Funeral Home 13 E. Grove Street Delmar, DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Non mall Due to (or as a consequence of): Z ue to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

burial-1

attending physician for use as the buria

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page 2 s

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, t

law requires that the death certificate be executed

Box 68760,

Division or Vital Records, P.O.

permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "n: any injury or other traumatic event, the Medic once.

Maryland 2121

Baltimore,

Physician

/Medical

Examiner

Funeral

Director

r tnan "natural", or Items 23a or 28a-f show the Medical Examiner must be notifiled at

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

Be

P

Certification:

Medical

DE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

6 ☐ Could not be

determined

20 No 1 ☐ Yes

29b. Signature and title of certifier

28a. Date of Injury (Month, Day Year) 5 Pending investigation

28b. Time of

28c. Injury at Work?

28d. Describe how injury occurred

21804

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

27. Manner of Death

2 Accident

3 ☐ Suicide

4 ☐ Homicide

1 Natural

1 🗂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO 32. Rajistrar's Signature

State Registrar

VPT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 11 18 15 144

| | | • | 1 - State of Maryland / Department of Heal State of Maryland / Department of Heal Certificate of De | | | ierie_ () () () | 03144 | | | | | |
|---------------------|--|----------------|--|--|---------------------------------------|-------------------------------|--|--|--|--|--|--|
| T | Dhysisi | 7 | 1. Decedent's Name (First, Middle, Last) | | 2. Date of Deat Month | Day Yeer | 3. Time of Death | | | | | |
| | Physicia /Medic | | Kathleen M. Kendall | | Feb. | 10,2008 | 7:05 рм | | | | | |
| | Examin | er | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Loc Good Samaritan Nursing Center Baltimos | | 7 | 4c. County of Dea | th | | | | | |
| | | | 3 | Under 24 Hrs. | | 9. Bir | thplace (State or Foreign | | | | | |
| | Funeral Director | ļ | 412-18-6900 1 M 2 K F 87 Yrs. Months Days F | Hours Min. | 8. Date of Birth (Month, Day, Nov. 28 | , 1920 Te | thplace (State or Foreign ountry) nnessee | | | | | |
| | and | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | | 10d. Inside City Limits | | | | | |
| | f sho | jo | MD Baltimore | | 1 X Yes 2 □ No | | | | | | | |
| | the 728a | Director | 10e. Street and Number 10f. Zip Code | | 10 | 0g. Citizen of What Co | ountry? | | | | | |
| | h with | | 1601 E. Belvedere Ave. 21239 | | | U.S.A. | | | | | | |
| Maryland 21215-0036 | deat | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispa If Yes, specify Cuban, N | anic Origin? (Spe Mexican, Puerto I | cify Yes or No- Rican, etc.) | 14. Race - Ame Black, Whit | | | | | | |
| | be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or Items 23e or 28e-f show event. The Medical Examiner must be notified at | by | 1 Never Married 2 Married 1 Yes 2 MNo | Specify: | | | Mhite | | | | | |
| ဂ ဂ | 72 ho | eted | 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired) | n ina most of workii | na | 16b. Kind of Business | /Industry | | | | | |
| V | Athin Ne. | Completed | Elementary/Secondary (0·12) College (1-4or 5+) Lab Tech & Sup | | | Medical Ma | mufacturing | | | | | |
| 7 | lled w tygies her ti | | | | | Maiden Sumame) | | | | | | |
| <u>a</u> | 2 should be filed within and Mental Hygiene. Is marked other than raumatic event. Its M. | Be c | | | | Dillingh | nam | | | | | |
| Ž | thould d Me mark matic | 2 | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and | | | | · · · · · · · · · · · · · · · · · · · | | | | | |
| <u> </u> | | | Dixie L. Cook 14815 Jarret | | | | | | | | | |
| ē, | ges 1 and 2 should to f Health and Men if Item 27 is marke or other traumatic | | 20a Method of Disposition 20b. Place of Disposition (Name of | D | ate | 20c. Location - City or | | | | | | |
| Ē | permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other 2 once. | | 1 ABurial 2 Cremation 3 ARemoval from State 1 Donation 5 Other (Specify) Cemetary, crematory or other place) Willow Mount Cemetary | Feb. 2008 | 18, | Shelbyvill | e, TN | | | | | |
| galtimore, | parim parim porta | | I Cellie fel A | | | c en stein | Mortuary, In | | | | | |
| ă | 20 5 3 8 | | James J. New Oustein 24 Second | d St., | New Fr | ceedom, PA | 17349 | | | | | |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, si shock, or heart failure. List only one cause on each line. | such as cardiac o | r respiratory arre | est, | Approximate Interval Between | | | | | |
| | Physician | | Immediate Cause (Final disease or condition ASPIRATION (WELLM | AILMOI | • | | Onset and Death | | | | | |
| | /Medical Examiner | | resulting in death) Due to (or as a consequence of): | | | | | | | | | |
| | LXammer | _ | | | | | | | | | | |
| / | pe) | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | | | | | | | |
| | al-tra | xar | that initiated events c. resulting in death) Last Due to (or as a consequence of): | | | | | | | | | |
| 58/60, | ificate be executed physician and as the burial-transit | | d | | | | | | | | | |
| 9 | | ledical | | | | | | | | | | |
| X D D | death cert e attendin | an/N | IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy | | 23d. Date of de | | | | | | | |
| | e death | hysician/M | in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) | Month | n Day Year | | | | | | | |
| Э | d by t | Phy | 9 🗆 Unknown | - Dodl | 23a Did tob | pacco use contribute t | a the cause of death? | | | | | |
| as, I | w requires that the death certif been signed by the attending should be detached for use a: | þ | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in ATAIM FIBALLIATION | | robably 4 Unknown | | | | | | | |
| Vital Records, | law reas bee | Completed | HYPERTENSION | | 24a. Was a | v prior to | utopsy findings available completion of cause of | | | | | |
| <u> </u> | : The law cate has l | Con | CITRONIL DYSTRUCTURE XIRWAY DIJE | ńed? death? 2 ☑ No 1 ☐ Yes | 1 ☐ Yes 2 ☐ No | | | | | | | |
| 7 [6 | rician: Th certificate rector, pag | Be | 25. Was case referred to medical examiner? | | | | | | | | | |
| 5 | Physic this c | 2 | | | | ence 6 Other (Spe | əcify) | | | | | |
| | ding After funer | Certification: | 1 ☑Natural 5 ☐ Pending (Month, Day Yeer) Injury Work? | 28d. Describe how injury occurred | | | | | | | | |
| DIVISION | Attan deatl ctor: y the | fica | 3 Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, lactory office | | | | lural Route Number, | | | | | |
| | after Dire | erti | 4 Homicide determined building, etc. (Specify) | | | | | | | | | |
| | To the Hospital or Attanding Physician: within 24 hours after death safe death To the Funaral Director: Atter this certification in the funeral director. | edical C | 29a. Certifier (Check only one) Check o | | | | | | | | | |
| | o the ithin 2 o the omple | Med | one) and manner stated. 29b. Signature and title of certifier / | 9d. Date signed (Mon | th, Dey, Year) | | | | | | | |
| | ⊢≯⊢ŏ | 0 | Mrulary MD DE | 8120 | 16. A 12Th 2008 | | | | | | | |
| | | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | | 100 14 | 2000 | | | | | |
| | 17 | | ROSEMANIE MARKAJ 5601 LOCH RAVEN BL | UD, BA | LT, M | D 2123 | 9 | | | | | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) FEB 2 1 2008 | | | | | | | | | |

| | | | For State Registrar | St | tate o | f Marylaı | | artmen ertificat | | | and M | lental Hy | gier Reg. I | -20 | 08 | 051 | 45 |
|----------|---|---------------------|---|-------------------------|-----------------------------------|---|-------------------------------|------------------------------|----------------------------|--------------------------|----------------------|---|-------------------|-------------------------|----------------------------------|---|---------------|
| | Physicia | _ | 1. Decedent's Name (First, Middle Antonia Lope | | | | | | | | | 2. Date of De Month Januar | [| Day 1, 20 | Year | 3. Time of De 8:30p | eath M |
| | /Medic Examin | | 4a. Facility Name (If not institution | | at and nu | mber) | | 4b. City, | Town, or | Location of | of Death | odiladi | | 4c. County | | зтогр | |
| | | | 6404 Sandy Spr | | oad | | | | Laur | | | | | rince | | | |
| | Funeral | | 5. Social Security Number | 6. Sex 1 ☐ M | 2 % F | 7. Age (In yrs | . last birthday Yrs. |) If Under Months | Days Days | If Under Hours | Min. | 8. Date of Bi (Month, D | ay, Yea | | Coui | | oreign |
| | Director | | 579-56-1890 Usual Residence of Decedent | | | 96 | | L | | | | Jan. 1 | 1, | 1912 | Guat | emala | |
| | ryland how | | 10a. State 10b. County | | | 10c. C | ity, Town or L | ocation. | | | | | | | | 10d. Inside City | |
| | ne Ma 8a-f s otifiec | Director | | ce Geo | orge | s | I | aurel | | | | | 40- | Citizen of \ | Marine Committee | 1 □ Yes 2 | E 1140 |
| | with th | Dir | 10e. Street and Number 6404 Sandy St | rina | Poar | ٩ | | 10f. Zip | | | | | rug. | USA | wnat Cou | nury : | |
| | filed within 72 hours after death with the Maryland Hygiene. Hydiene. When ther than "natural" or items 23a or 28a-f show ther than "natural" or items 23a or 28a-f show ant, the Medical Examiner must be notified at | Funeral | 11. Marital Status | 12. V | Was Dec | edent Ever in l | J.S. 13 | | | spanic Ori | gin? (Sp | ecify Yes or No Rican, etc.) | D- | 14. Rac | | can Indian, | |
| Q | after or ite | | X XNever Married 2 ☐ Marri | ed 1 | Armed Fo 1 ☐ Yes If Yes, Gi | 2 X No | | 1 ves, spe | | | | Guatema | | | ck, White, | etc. White | |
| 2000 | hours ural", al Exa | d by | 3 Widowed 4 Divorced | | Year or D | ates: | 1 16a Daa | edent's Usu | | | | dacema | | . Kind of B | | | |
| <u>.</u> | in 72 n "nat Medica | Completed | 15. Decedent (Specify only highes | t grade cor | mpleted) | 4 4 5 - 1 | i (Giv | e kind of wo DO NOT u | rk done a | uring mos | t of work | ing | | . Killa ol bi | usii less/ii i | uustiy | |
| 7 | d with giene. er than | mo. | Elementary/Secondary (0-12) 4 | | College (| 1-40f 5+) | | Nan | ny | | | | Pr | ivate | Res | idence | |
| מום | be file tal Hy d othe event, | Be | 17. Father's Name (First, Middle, | Last) | | | | | | | | e (First, Middle | | | ne) | | |
| <u> </u> | d 2 should be filed within 7 th and Mental Hygiene. 77 is marked other than "r traumatic event, the Med | မ | Pedro Lopez | nin /Timo | Drint) | | 10h Mai | lina Addross | (Street | | | da Tru | | | Stata Zii | n Cada) | |
| <u> </u> | nd 2 sl Ith an 27 is r traur | | 19a. Informant's Name/Relations Jacqueline Poir | | | iogo | 195. IVIAI | | | | | | | | | | |
| ā, | item | | 20a. Method of Disposition | | • | 20b. | Place of Disp | osition (Na | me of | i | | Id, Colu | | . Location | | | |
| altimor | Page Trent c ant: If ury or | | 1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S | | ovai trom | State | edar H | _ | | | Feb | , | Su | itlan | d, Ma | aryland | |
| | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "naturali", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 21. Signature of Funeral Service | Licensee | 0 | | F | 22. Name a ranci | nd Addres | s of Facili Coll | hv | Funera: | l He | ome I | nc. | | |
| . | Physician /Medical Examiner | Examiner | 23a. Part1. Enter the disease, or shock, or heart vailure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. E | Respi Due to Letas | caused the despach line. Iratory (or as a conse | Failu equence of): Uterin | re | de of dyin | g, such as | cardíac | or respiratory | arrest, | | | Approximate interval Between Onset and De | en eath |
| <u> </u> | w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit | Physician/Medical E | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1□ Yes 2□ No 9□ Unknown | | 1□Live | tcome pf preg birth 2 Fe nant at time of | tal death 3 | □Ectopic p | | | | | | | ate of deliv | ery Day Ye | ar |
| JS, P. | requires that the een signed by tha nould be detache | þ | Part II. Other significant condition | | - | | esulting in the | underlying | cause give | en in Part I | | | | co use con | | the cause of dea | |
| ecoras | law requas been 2 should | letec | | | | 2.0 | | | | | | 24a. Wa | s an | 24b. | Were aut | opsy findings av | |
| Ĭ | The ate h page | Completed | | | | | | | | | | per 1□ Yes | | 1? | prior to co death? 1 ☐ Yes | ompletion of cau 2 □ No | se of |
| VItal | Physician: r this certific ral director, | o Be | 25. Was case referred to medica examiner? 1 ☐ Yes 2 No | Hosp | oital: 1 🗆 | Inpatient 2[| ⊒ ER/Outpati | ent 3□ D | OA Othe | | | th <i>(Check only</i> ome 5 X Res | | e 6 🗆 Oti | her (Sneo | ifv) | |
| - | ig Phy ter this | H | 27. Manner of Death | | 28a. Date | | 28b. Time Injury | of | 28c. Injun Worl | / at | aronig i k | 28d. Describe | | | | -97 | |
| SIOIS | Attending or death. ector: After by the fune | atio | 2 ☐ Accident investig | gation | | | | М | 10 | Yes 2 □ | No | | | | | | |
| <u>=</u> | tal or Att s after do al Direct ed in by | Certification: | 4 ☐ Homicide determ | ined | build | e of injury - At ling, etc. <i>(Spec</i> | cify) | | | | | City or To | òwn, S | tate) | | al Route Numbe | <i>∍r</i> , |
| | To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fun | edical | 29a. Certifier (Check only one) Certifyir | g Physicia Examiner: | : On the I | e best of my ki basis of exami nner stated. | nowledge, de nation and/or | ath occurred investigatio | d at the tir n, in my o | ne, date a pinion, de | nd place ath occu | , and due to th rred at the time | e caus e, date | e(s) and m and place | anner as , and due | stated. to the cause(s) | |
| | To the vithi comp | Me | 29b. Signature and title of certifie | r | | | 10 | 29 | c. License | | | 222 | 29d. | Date signe | ed (Month | , Day, Year) | |
| 1 | 2 | | , // | un | 7 | | 40 | | Lic | | 1006 | ,0233 | | Feb: | ruary | 6, 200 | 18 |
| | | | 30. Name and address of person Nan Wang, MD | | .0 Co | nnecti | ut Ave | | Kensi | ngto | n, M | D 20895 | 5 | | | | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | | | egistrar's Sig | nature | sole | P | | | | | | | | |

08-01280 Jailyn Liciaga Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Jailyn Liciaga | State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar Certificate of Death Reg. No. Reg. No. |
|--|--|
| Physician | 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death |
| Medical Examine | Jailyn Liane Liciaga Month Day Year Pebruary 14, 2008 0919 hrs |
| | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death |
| | Atlantic General Hospital Berlin Worcester |
| Funeral | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign |
| Director | 212-81-1338 1 M 2 XF Yrs. 2 9 Hours Min. 12-5-2007 Country Maryland |
| * | Usual Residence of Decedent |
| w any | 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No |
| d ish | MD wicomico Parsonsburg |
| Le Lu the Maryland a or 28a-f sh tified at once | 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? |
| $1 \mathcal{L}_{\mathcal{L}} \mathcal{L}_{\mathcal{L}}$ r death with the Maryland or items 23a or 28a-f show must be notified at once. | 7468 Madeline Circle 21849 USA |
| er death with , or items 23 r must be no | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- I Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. |
| er dez | 1 Yes 2 X No |
| rs aftural" ural" | 3 Widowed 4 Divorced If Yes, Give Year or Dates 1 X Yes 2 No specify: Puerto Rican Specify: Hispanic 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16b. Kind of Business/Industry 16c. Kind of Business/Industry 16c |
| 2 hou "nat 1 Exa | Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired) |
| thin 7 than than | 0 Never Worked Never Worked |
| 5-0036 ed within 72 hour lygiene. other than "natur the Medical Exan | 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) |
| 21; be fill mtal It rked ent, 1 | Francisco Liciaga Amanda Wilkinson |
| MD 21215-0036 at 2 should be filed within 7 lith and Mental Hygiene. In 27 is marked other than aumatic event, the Medica. To Be Comple | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| , MD 21215-0036 and 2 should be filed within 72 hours af eath and Mental Hygiene. tem 27 is marked other than "natural traumatic event, the Medical Examin To Be Completed by | Amanda Wilkinson - mother 7468 Madeline Circle, Parsonsburg, MD 21849 |
| more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Intel If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once To Re Commleted by Finneral Director | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State |
| Page nent o | 4 Donation 5 Other Specify: Jerusalem Cemetery 2-18-2008 Parsonsburg, MD |
| Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health, and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med To Re Comm | 21. Signature of Funeral Segvice Licensee 22. Name and Address of Facility Bounds Funeral Home |
| m 80 E E | 71 blog Helly Lake 705 E. Main Street, Salisbury, MD 21804 |
| Physician | 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and |
| /Medical `Examiner | Immediate Cause (Final disease a Complications of Prematurity Death |
| | or condition resulting in death) Due to (or as a consequence of): |
| d | Sequentially list conditions, if any, leading to Immediate Due to (or as a consequence of): |
| | Course. Enter Underlying Cause (Disease or injury that initiated C |
| ted f Insit Examiner | events resulting in death) Last Due to (or as a consequence of): |
| execu an and al - tra | X UNPENDED ☐ AMENDED 23a,27 per ME g878 4/24/08 amh |
| 760, cate be physici he buri | IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery |
| ox 6876(eath certificate attending phy for use as the best cisician/Ma | 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year |
| the death certificate the death certificate by the attending phy ched for use as the by Physician/Me | 1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) 9 Unknown |
| D. E. tribe of tribe of by the arched | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |
| P.G. res that signed be det | 1 Yes 2 No 3 Probably 4 V Unknown |
| Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by P | 24a. Was an 24b. Were autopsy findings available |
| e law e has ge 2 s | autopsy prior to completion of cause of performed? death? |
| tal Recision: The certificate ector, page | 25. Was case referred to medical 26.Place of Death (Check only one) 1 ✓ Yes 2 No 1 ✓ Yes 2 No |
| Vital Rec ysician: The his certificate director, page | examiner? Hospital: |
| of Viring Physical After this inneral dir. | 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred |
| ision of ' Attending Ph r death. ector: After t by the funeral cation: T | 1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No |
| risical rectoring the properties of the properti | 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City |
| Division ospital or Attending rours after death. neral Director: After filled in by the func | 3 Suicide 6 Could not be determined (Specify) |
| Hospi 24 hot Funce ely fil | 29a. Certifler Control of the cause (s) and manner as stated. |
| Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the the Medical Certification: To Be Completed by Physician/Mi | one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |
| F S F S F | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) |
| - CAA | O.C.M.E. February 15, 2008 |
| Office | 30. Name and address of person who completed cause of death (Item 23a) |
| | Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 |
| State | 31. Date filed (Month, Day, Year) FEB 19 2008 |
| Registra | ILD TO TO TOWN TO TOWN |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Day Year Physician Herbert A. Lux 03:29 AM 2008 rebruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake
5. Social Security Number 6. Sex Medical Center Bel Air, Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 5/9/1917 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Year) 1 ☑ M 2 ☐ F 215-09-9629 90 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Harford Pylesville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1307 Red Bridge Road 21132 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1945–46 1 Never Married 2 Married White 1 ☐ Yes 2 🖾 No Specify. ģ Specify: 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Technician Oil Burner and Mental Hygie Is marked other injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic ev Peter Lux Margaret Hoffman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1306 Red Bridge Road, Pylesville, MD James V. Lux, Sr./Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary's Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2/18/2008 Pylesville, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA Approximate Interval Between Onset and Death Part Liner the dilease, or our ilications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Aute Renal Failure **Physician** 2 days /Medical Due to (or as a consequence of): Examiner 3 days Acute Coronary Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed Coronary artery disease and Due to (or as a consequence of): Box 68760, attending physician Physician/Medical law requires that the death certificate the as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy page 2 should be detached for Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9□Unknown 9 HInknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No Vital Hospital or Attending Physician: thours after death. Funeral Director: After this certifice completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To ō 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DS3186 12,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 1/2001

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State Registrar

MID

32. Registrar's Signature

TIMMEY

615 W. M. Phail Rd Bel Air, MD 21014

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) FEB 0 6

Kshama Garg, M.D. 1500 Forest Glen Rd., Silver Spring, MD 20910

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Be††y Lorraine Mills ,2008 Feb 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 15504 Dellinger Road Williamsport Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Sept.3, 1947 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1□M 2∏F Yrs. 220-82-0135 60 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Williamsport Maryland Washington 10e. Street and Number 10g. Citizen of What Country? 15504 Dellinger Road 21795 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes ≥2√∑No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clyde Milton Mongan Elizabeth Alverta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David G. Mills - Son 3608 Harpers Ferry Rd. Sharpsburg, Maryland 21782 20a. Method of Disposition

1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State • 4 ☐ Donation Greenlawn Mem. Park 5 Other (Specify) Feb.11,2008 Williamsport, Maryland 21. Signature of Funeral Service Osbonned Fourner Entith Home, P.A. A25 S. Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or helif failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) months 1 rams yerse Due to (or as a consequence of): Secure liable list and lians if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, for use as the δ signed I page 2 certificate has or Attanding Physician: funeral director this After after death Diractor: filled in by

Physician

/Medical

Examiner

Directo

Funerai

Completed by

Be

Funeral

Director

ar than "natural", or Itams 23a or 28a-f show the Wedical Examiner must be notified at

filed within 72 hours after

Hygiene.

Pages 1 and 2 should be file ment of Health and Mental Hy tent: If item 27 Is marked oth

othar

permit. Pages 1
Department of F.
Important: If its
any injury or otl

Physician

/Medical

Examiner

Examiner

Physician/Medical

þ

Be Completed

Certification: To

Medical

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day Year) 28c. Injury at Work?

1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Sign#tur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

046473

DM Hamdan,

31. Date filed (Month, Day, Year) State Registrar FEB 1 1 2008

within 24 hours a To tha Funaral E

completely

| | | Please | Type or Prir | | | | | _ | | | |
|--|------------------|---|--|------------------------------------|--------------------|---------------------------------------|--|---------------------------------|------------------------|----------------------------|---|
| | | For State | State of Ma | aryland | | | Health and N | lental Hy | giene | | |
| _ | | Registrar | | | Ce | rtificate of | Death | | Reg. No. | 1- V. V. L | 3 0515 |
| Physicia | an | Decedent's Name (First, Middle, La | , | | | | | 2. Date of De Month | Day | Year | 3. Time of Death |
| /Medic Examin | | George B. Mar: 4a. Facility Name (If not institution, give | | | | 4b. City, Town, o | or Location of Death | Februa | 1 ry 2 | , 2008 County of Deat | 1:00 A M |
| LAGIIIII | či s | Springtime Home | . 1 | iving | | Bowie | | | | rince G | |
| Funeral | | Social Security Number 6. 8 | Sex 7. Ag | e (In yrs. la | ast birthday, | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Bir (Month, Da | rth | | hplace (State or Foreign untry) |
| Director | | 577-09-7400 Usual Residence of Decedent | 92 | 2 | Yrs. | , | | 4/16/ | 1915 | Was | hington,DC |
| yland low at | | 10a. State 10b. County | | 10c. City | , Town or L | ocation | | | | | 10d. Inside City Limits |
| e Mar ta-f sk tified | Director | Virginia Fairfa | ıx | A. | lexano | dria | | | | | 1 □ Yes 2 🛣 No |
| vith th | Dire | 10e. Street and Number | 0 | | | 10f. Zip Code | | | - | zen of What Co | untry? |
| 72 hours after death with the Maryland 72 hours after death with the Maryland inatural", or items 23a or 28a-f show dieal Examiner must be notified at | eral | 9420 Mt. Vernon | Circle 12. Was Decedent | Ever in 11 9 | 2 10 | 2230 | | anife Van an Na | | USA 14. Race - Ame | ringa Indian |
| fter d | Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Married | Armed Forces? 1 Yes 2 1 | Vo | 5. 15. | | Hispanic Origin? (Sp ean, Mexican, Puerto | Rican, etc.) |)- | Black, White | |
| ours a | þ | 3XXWidowed 4 ☐ Divorced | If Yes, Give Year or Dates: | | | 1 ☐ Yes 2 🛣 No | Specify: | | | Specify: | White |
| 72 ho | Completed | 15. Decedent's E (Specify only highest gr | ducation ade completed) | Į | 16a. Dece (Give | edent's Usual Occu | pation during most of work d) | ing | 16b. Ki | nd of Business/ | Industry |
| within ene. than | dmo | Elementary/Secondary (0-12) 7th | College (1-4or 5 | i+) | | DO NOT use retire Bricklaye | | | Ma | sonrv | |
| filed Hygi other ent, ti | Be Co | 17. Father's Name (First, Middle, Last |) | | | DITCKTAYE | 18. Mother's Name | e (First, Middle, | <u> </u> | | |
| uld be Aental rked tic ev | To B | John Marino |) | | | | Mary 1 | Louise | Roge | r | |
| 2 short and N is ma | | 19a. Informant's Name/Relationship | | | 1 | | and Number or Rur | al Route Numb | er, City o | r Town, State, Z | |
| and lealth m 27 | 9 | George B. Marino, | Jr./ Son | Jack Bi | | | non Circle | | | | |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Insportant: If frem 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ | | ce | emetery, cre | osition (Name of ematory or other pla | ce) | Date | | cation - City or | |
| artmel | | 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lee | | rest | | | tery 2-5- | | | nton, M | |
| Depa Impo | | V/16/11/1602 | | | | | mons Isla | _ | | | |
| | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that caused | the death | . Do not en | ter the mode of dyi | ng, such as cardiac | or respiratory a | ırrest, | | Approximate Interval Between |
| Physician | Ì | Immediate Cause (Final disease or condition | Car | 20010 | 0 1 | Ampleo | | | | | Onset and Death |
| /Medical Examiner | | resulting in death) | Due to (or as | a consequ | ence of): | 1000 | V(- | | | | |
| | 5 | Sequentially list conditions, | b | a consequ | ence of): | | | | | | |
| uted d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | 540 10 (01 40 | a oonooqu | 01100 017. | | | | | | |
| be executed cian and burial-transit | | resulting in death) Last | Due to (or as | a consequ | ence of): | | | | | | |
| | lical | • | d | | | | | | | | |
| The law requires that the death certificate by ate has been signed by the attending physicionage 2 should be detached for use as the but | Physician/Medica | IF FEMALE: | 23c. If yes, outcome | nf prognar | 2011 | | | | | | |
| attend for us | cian | 23b. Was decedent pregnant in the past 12 months? | 1 ☐ Live birth 4 ☐ Pregnant at | 2 Fetal | death 3[| □Ectopic pregnanc | у | | 2 | 23d. Date of deli Month | very Day Year |
| t the d ached | hysi | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9□Unknown | | | | | | | | |
| w requires that the de been signed by the s should be detached | by P | Part II. Other significant conditions | contributing to death bu | ut not resul | lting in the u | ınderlying cause giv | ven in Part I. | 23e. Did t | tobacco u | se contribute to | the cause of death? |
| require | | Failure | to to | rue | * | <u> </u> | | 1 🗆 ' | Yes 2[| □No 3□Pr | obably 4 Unknown |
| e law has be | Completed | | | | | | | 24a. Was autop | psy | prior to o | topsy findings available completion of cause of |
| The The licate | | | | | | | | 1 Yes | 2 1 No | death? 1 ☐ Yes | 2□ No |
| s certi | o Be | 25. Was case referred to medical examiner? | Hospital: 1 ☐ Inpatie | nt 2DE | R/Outpatie | nt 3 DOA Oth | 26. Place of Deat ner: 4 ☐ Nursing Ho | | | | Assisted |
| g Phy ter this | n: To | 27. Manner of Death | 28a. Date of Injui | rv | 28b. Time o | | | 28d. Describe l | | | Living |
| endin sath. or: Af | atio | Natural 5 Pending investigation | 1 | / rear) | IIIJuiy | | Yes 2 □No | | | | |
| or Att fter de Direct | Certification: | 3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined | 28e. Place of injubulding, etc | ry - At hor c. <i>(Specify)</i> | me, farm, st | reet, factory, office | | 28f. Location (3 City or Tox | Street an wn, State | d Number or Ru) | ral Route Number, |
| pital ours a leral C | | 29a. Certifier La Certifying Ph | ysician: To the best of | of my know | leah anhaly | th occurred at the ti | me date and place | and due to the | 001100(0) | and manner of | otatod |
| To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page | Medical | (Check only one) 2 Medical Example (Check only one) | niner: On the basis of and manner sta | examinati | ion and/or ir | nvestigation, in my | opinion, death occur | red at the time, | date and | I place, and due | to the cause(s) |
| To th within To th comp | Me | 29b. Signature and till of certifier | | | | 29c. Licens | se number | | 29d. Dat | e signed (Month | n, Day, Year) |
| | | | | | | | D57028 | | 02 | 4-08 | |
| 1110 | | 30. Name and address of person who | completed cause of de | eath (Item: | 23a) (Type, | Print) | | λ | | | |
| Stat | 10 | 31. Date filed (Month, Day, Year) | 32. Registra | ar's Signati | 110 ge ure | y Avenu | e #231 | Annapa | 0/15 | MD | 21401 |
| Registra | _ | FEB 0 5 | 2008 | we | K. | Specie | | | | | |
| | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month O2Day 03 08 4b. City, Town, or Location of Death 4c. County of Death EASTON If Under 1 Year If Under 24 Hrs. Manths Days Hours Min. 8. Date of Birth (Month, Day,) 9. Birthplace (State or Foreign Country) Maryland -26-078 Days Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Talbot Maryland Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21601 USA 610 Dutchmans Lane 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 💥 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify: Specify White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Beautician Cosmetology 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Galloway unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14192 Cuddy Loop, #102, Woodbridge, VA 22193 Daniel J. Burtis/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 2/5/08 Edgewater, MD 21. Signature of Europeal Sovice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 21 ue to (or as a conse uence of) hydration Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the to (of the a consequence of) eme Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐Yes 2,2No Month Vear Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an Venou 2 No Yes 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 ☐ Yes 2 2 No

Physician /Medical Examiner

and

attending physician

the

has

After this certificate

within 24 hours a

Hospital or Attending Physician:

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Directo

Funeral

Completed by

Be

ပ

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner

death with the Maryland

Examiner Physician/Medical þ Be Completed

မ

Certification:

Medical

25. Was case referred to medical examiner?

5 Pending investigation 6 ☐ Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) FEBRUARY 4, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

318 S. Aurora St., Apt. D, Easton, MD 21601 Lakshmi Vaidyanathan, M.D. 31. Date filed (Month, Day, Year)

State Registrar

FEB Q 5 2008

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Joseph Daniel McMahon February 2008 1:30 A^{M} /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1⊠M 2□F 198-18-2430 82 Director 22, 1925 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Maryland Anne Arundel Annapolis Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2523 Tudo Court 21401 U.S.A. Pages 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene.

Mart: If item 27 is marked other than "natural", or Items 23: Mart: If item 27 is marked other than "natural", or upon treumatic event, the Medical Examiner must ury or other traumatic event, the Medical Examiner must Funeral . Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1XYes 2□No If Yes, Give Year or Dates: 1945–64 1 Never Married 2X Married 1 ☐ Yes 2**XX**lo Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Daniel McMahon Catherine Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2523 Tudo Court Annapolis, Maryland Vera Gordon McMahon/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or otl
once. 1XDBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 2/7/2008 Crownsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home - Mie 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of): Dehydration Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-tran Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2**.....**No 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No npatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

the Maryland

Baltimore, Maryland 21215-0036

Items 23a or 28a-f show

Certification: To

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1X Natural 5 Pending investigation injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in my opinion death and the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

Hospital or Attending Physician: The law requires that the death certificate be executed

After

24 hours after death.

The Funeral Director: A pletely filled in by the fu

within 24 ho

To the Fun

completely i

Medical

Division or Vital Records, P.O. Box 68760

Michael Adam

Anne Arundel Medical Center

29d. Date signed (Month, Day, Year) Feb. 3, 2008

30. Name and address of person who completed callise of death (Item 23a) (Type, Print)

and manner stated

C03451

29c. License number

2001 Medical Pkwy, Annapolis, MD 21401

31. Date filed (Month, Day, Year) FEB 05 2008 32. Rujistrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Augusta February 2 2008 Year 8:30 р м McGinley /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Heritage Harbour Health Annapolis Anne Arundel 6. Sex Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F 96Yrs. 194-07-3696 Director Dec. 19,1911 Allentown, PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the M. dical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Anne Arundel Annapolis 4 6 1 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2700 South HavenRoad 21401 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes **2**\tilde{\text{X}}\No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing Inspector General Cigar Factory 08 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Toth Theresa ပ Niedermeyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis McGinley 988 Round Top Drive Annapolis,MD 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 N Bunal 2 □ Cremation 3 □ Removal from State Sacred Heart Cem, 4 Donation 5 Dother (Specify) 02/07/2008 Allentown, PA 21. Signature of Funeral Service License 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Ave Annapolis MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the 9□Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 DUNKnown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a, Was an has 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: P 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide portifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State Registrar

29b. Signature and

of certifier

31. Date filed (Month, Day, Year) FEB 0 5 2008

29c. License number

29d. Date signed (Month, Day,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day **Blanche** C. 5:50pM Main February 2,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 103 Huse Drive Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 🗆 M 215-52-9372 Director 92 March 2,1915 Duncannon, PA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Anne Arundel Annapolis Director 1 X Yes 2 □ No 10e. Street and Number 103 Huse Drive 10f. Zip Code 10g. Citizen of What Country? 21403 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 💹 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 X Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Worker State of Maryland 12 other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Carnes Carrie Elizabeth ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie Main Daughter 11715 Whittier Road Mitchellville, MD 20721 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans 4 ☐ Donation 5 ☐ Other (Specify) 2/5/08 Crownsville,MD 21. Signature of Funaval Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Ave Annapolis,MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as car liac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, to a very last to in registration cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical the as IF FEMALE: use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4□Pregnant at time of death 5 Other (specify) the py signed by not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 100 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No certificate | 25. Was case referred to medical examiner? director Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No P 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation Injury n 24 hours after death.

The Funeral Director: A pletely filled in by the funeral filled in by t 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of de ath (Item 23a) (Type, Print) Jack Lichtenstein, M.D. 207 Ridgely Ave. Annapolis, MD 21401 31. Date filed (Month, Day, Year) Registrar's Signature State FEB 0 5 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 2350 PENNY JANE MACK ebruary 10 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Easton Talbot Memorial Hospita If Under 1 Year | If Under 24 Hrs 6. Sep 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 X F Director 174-36-8654 61 12/9/1946 PA Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Director 1 ☐ Yes 2 🙀 No CHESTERTOWN MD **KENT** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 237 MERGANSER DR. 21620 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED HEALTHCARE 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ဥ WILLIAM PENN MACK JANE ELIZABETH BELLIS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SONDRA ARCHER/DAUGHTER 412 3RD ST. PO BOX 404 CRUMPTON, MD 21628 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION 2/13/2008 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA
130 SPEER RD. CHESTERTOWN, MD 21620 23a. Dani. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonia ay /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by disease 1 | Yes 2 | No 3 | Probably 4 | Winknown Corona 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s stenosi perform certificate 1∐ Yes 2**X** No 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No After this 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day ↑ Natural 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 TYes 2 ☐ Accident 2 🗌 No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) FEBRUARY 11, 2008 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

S.

s Signature

NID

2008

32. Regist

Washington St.

Easton, MD 21601

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|----------------|--|-----------------|--|---|------------------------------------|----------------------------------|-------------------------------------|-----------------------|--|---------------------------------------|----------------------|--------------------------|---------------|---|
| A | MENDEI |) # | 1 - For State Registrar 10e, FH, 1. Decedent's Name (First, Middle | TCHD, 2/04/ | 08 pl | na Ce | rtificate | of De | ath | | Reg. No. | 200 | 8 | 05156 |
| | Physici /Medi | | THOMAS E. | MOFFATT | | | | | | 2. Date of De Month JANUARY | Day | | ear 08 | 3. Time of Death 6:30AM |
| | Examir | ner | 4a. Facility Name (If not institution | | | | | | cation of Death | 1 | | County of | | |
| - 78 | Funeral | | 5. Social Security Number | 6. Sex 7. Ag | ge (In yrs. | last birthday) | If Under 1 | | Under 24 Hrs. | 8. Date of Bir | rth | TALBO 9 | . Birthpl | ace (State or Foreign |
| Si. | Director | | 510-10-0197 | 1 XM 2 F | 91 | Yrs. | Months | Days H | lours Min. | NOV. 1 | 9,191 | 16 | Count | KS KS |
| | land ow | | Usual Residence of Decedent 10a. State 10b. County | | 10c. Cit | ty, Town or Lo | ocation | | | | | | 10 | Od. Inside City Limits |
| : | a-fsh iified | ctor | MD TALI | BOT | | ST | . MICH | IAELS | | | | | | 1 XYes 2 □ No |
| 3 | with the Marylan a or 28a-f show be notified at | Director | 10e. Street and Number | | | | 10f. Zip (| Code | | | 10g. Citiz | zen of Wha | at Count | iry? |
| : | ns 23a must | Funeral | 305 CHEW ST. | 305 E. CHE | Ever in U | | | .663 | nic Origin? (S | pocify Voc or No | | U : 14. Race - | SA America | an Indian |
| 036 | r 7z nours arter death with the Maryland "natural", or items 23a or 28a-f show dical Examiner must be notified at | þ | 1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced | Armed Forces? | • | I . | if Yes, specif | | necongnii: (S Mexican, Puert pecify: | pecify Yes or No o Rican, etc.) | | | White, e | etc. |
| م | nin 72 noi e. an "natur Medical E | eted | 15. Decedent (Specify only highes | s Education | - 1 | 16a. Dece | dent's Usual | Occupation | na mast of wor | kina | 16b. Kir | nd of Busin | ness/Ind | ustry |
| 21215-0036 | | Completed | Elementary/Secondary (0-12) | College (1-4or | 5+) | | DO NOT use PERVIS | | ng most of wor | King | ATD | אבר א מריים | ti CO | MD t NV |
| | Hygie other ent, th | Be Co | 17. Father's Name (First, Middle, I | _ast) | | 30. | ERVATO | | Mother's Nam | ne (First, Middle, | | | r co | MPANY |
| | 6 9 34 55 | To B | STEPHENSON G. | MOFFATT | | | | | MYRTL | E WINTER | RROWD |) | | |
| Jar | yes - I and z should be filed with to f Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the M | | 19a. Informant's Name/Relationsh | | | | | | | ıral Route Numb | | | ate, Zip | Code) |
| | Healt Healt Healt ther | | SUE MULHERN/DAT 20a. Method of Disposition | GHTER | 20h F | | | | E, MED | IA, PA I | | | | 04-1- |
| saitimore, | таges ment of I | | 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp | 3 □Removal from State | | Place of Dispo cemetery, crei | | | 2/6 | | | cation - Cit | - | vn, State |
| | | | 21. Signature of Funeral Service L | | M | | | | Y 2/6 | | | TON, | | |
| ñ | Depar Impor any Ir | | | 131 | l | | 200 S. | S, HE HARR | LFENBE ISON S' | IN & NEW F. EASTO | VNAM ON, M | FUNE D 216 | RAL 1 501 | HOME PA |
| | hysician | YG I | 23a. Part1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death) | complications that caused only one cause on each li | ne. | , , | 10 | of dying, su | uch as cardiac | or respiratory a | rrest, | | | Approximate Interval Between Onset and Death Smirte |
| | /Medical xaminer | | resulting in death) | Due to (or as | - | 1 | | | | | | | | Zoyears |
| § ——— | | Jer | Sequentially list conditions, | b. Due to (or as | | | 30 | | | | | | | De pers |
| J, evenifed | sician and burial-transit | Examiner | Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | | | | | | | | | | |
| o B | ician a | E E | resulting in death) Last | Due to (or as | a conseq | uence of): | | | | | | | | |
| 700 | phys s the | edic | | d | _ | | | | | | | | + | |
| O. DOX | within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the | Physician/Medic | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown | 2 Feta | Ideath 3 | Ectopic prec Other <i>(sp</i> ec | | | | 2 | 3d. Date o Month | | ry Day Year |
| . tet | ed by detac | | Part II. Other significant condition | ns contributing to death b | ut not resi | ulting in the ur | nderlying cau | ıse given in | Part I. | 23e. Did to | obacco us | se contribu | ite to the | e cause of death? |
| COLDS, | an sign | ed by | hypertensun | | | | | | | 1 🗆 ' | Yes 2 |]No 3[|] Proba | ably 4. Hnknown |
| | as bee | Completed | hyperlyjdemia | | | | | | | 24a. Was | | 24b. Wei | re autop | sy findings available apletion of cause of |
| T The | page | Com | // / | | | | | | | perfo | rmed3 | dea | th? Yes 2 | |
| v Itali | certifi | Be | 25. Was case referred to medical examiner? | Hospital: | | | | Othor | | th (Check only o | | | | |
| 5 4 | er this | ٦. ا | 1 Yes 2 No 27. Manner of Death | 28a. Date of Inju | ry | ER/Outpatien 28b. Time of | | c. Injury at Work? | □ Nursing H | ome 5 XResid | | | Specify) |) |
| di di | ath. or: Aft ne fun | atio | 1∕☐Natural 5 ☐ Pending 2 ☐ Accident investiga | | y Year) | Injury | М | Work? 1 ☐ Yes | 2 □ No | | | | | |
| tal or Affe | within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | Certification: | 3 Suicide 6 Could no 4 Homicide determin | | ury - At ho c. <i>(Specif</i>) | ome, farm, stre | eet, factory, o | office | | 28f. Location (5 City or Tou | | Number o | or Rural | Route Number, |
| the Hospi | in 24 hou the Fune ppletely fill | Medical | one) 2 Medical E | Physician: To the best xaminer: On the basis of and manner sta | f examina | wledge, death tion and/or inv | n occurred at vestigation, in | the time, d | ate and place n, death occu | , and due to the rred at the time, | cause(s) date and | and manne place, and | er as sta | ited. the cause(s) |
| P | To To | | 77 - 60 - | ische M | 7 | | | License nur | | | 29d. Date | signed (A 31 08 | 1onth, D ₹ | ay, Year) |
| 6. | +VA | | 30. Name and address of person w | | | | Print) | Suite | 16 | aspn 1 | UD | 210 | 50 1 | / |
| | Stat Registra | | 31. Date filed (Month, Day, Year) FEB 0 4 | 2008 32. Projistra | ar's Signa | ture | - | : | | | | | | |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day OSCAR W. MOELLER Feb 2008 11:40 AM /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City Town or Location of Death 4c. County of Death Examiner Genesis HealthCare The Pines Talbot Easton If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Months Days Hours Min Director 219-14-0646 83 FEB 28,1924 MARYLAND Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits Director 1 XYes 2 □ No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the M-dical Examiner must be ready injury or other traumatic event, the M-dical Examiner must be ready. 14 S.E. DUKES AVE Funeral 21601 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 XYes 2 ☐ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: à Specify: WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR MONOTYPE &LINOTYPE **PRINTING** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OSCAR J. MOELLER MINNA K. HEIL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY T. MOELLER/WIFE 14 S.E. DUKES AVE., EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐Donation 5☐Other (Specify) JOSEPH'S CEMETERY 2/8/2008 CORDOVA, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA JOHN MERCERON R 200 S. HARRISON ST EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician acatal arrhythmic mrutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner tonglor Sequentially list conditions, any beautiful in included and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Theroscieuss use as the burial-trar Due to (or as a consequence of) Box 68760, attending physician be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No. 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ hyperdism 1 ☐ Yes 2x No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 2 autopsy perform page, certificate epression 25. Was case referred to medical or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No ို 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 2 ☐ Accident 5 Pending investigation Funeral Director: A etely filled in by the fi 1 ☐ Yes 2 ☐ No death. 6 Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 24 the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) CHMANS LAND MD 610 ROWL 1 CHAEL 32_Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Oscar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Marvland / Department of Health and Mental Hygiene

| | | | 1 - State Registrar | State of Ma | | epariment of F Certificate of | | , 0 | ene I. No. o o o o | 07150 |
|------------|---|---------------------|--|---|---------------------------------|--|--|---|---|---|
| * | Physici /Medic | | 1. Decedent's Name (First, Middle, Las Charles O | | Mastin | | | 2 Date of Death | Day Year 7 3, 2008 | 3. Time of Death |
| | Examir | | 4a. Facility Name (If not institution, give | | | | r Location of Death | restact | 4c. County of Death | 3.33 |
| | | | 1212 Frederick A | | | Salis | | | Wicomi | |
| | Funeral Director | | 5. Social Security Number 6. S 496-12-5848 Usual Residence of Decedent | ex 7. Age | (In yrs. last birth | Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, 1) | | lace (State or Foreign try) MO |
| | land ow | | 10a. State 10b. County | | 10c. City, Town of | or Location | | | 1 | 0d. Inside City Limits |
| | a-f sh | tor | Maryland Wicomic | :0 | Salisbu | ıry | | | | XXYes 2 □ No |
| | ith the |)ire | 10e. Street and Number | 1 | | 10f. Zip Code | | 100 | . Citizen of What Cour | try? |
| | sath w | ral | 1212 Frederick A | | | 21801 | | | USA | |
| 36 | be filed within 72 hours after death with the Maryland ital Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral Director | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates: | ver in U.S. | Was Decedent of Head of Four Pressor of Four Presso | lispanic Origin? (Spa an, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | 14. Race - Americ Black, White, Specify: | |
| 9 | 2 hou latura ical E | ted | 15. Decedent's Ed | ucation | 16a. D | ecedent's Usual Occup | ation | 16 | Bb. Kind of Business/Inc | |
| 21215-0036 | thin 7 te. lan "n Medi | Completed | (Specify only highest gra | de completed) College (1-4or 5- | +) (() | Give kind of work done ife. DO NOT use retire | during most of work d) | ing | | • |
| | filed wi Hygier ther th | | 12 | <u>5</u> + | | CLERGY | | | RELIGIO | N |
| Maryland | be eve | Be c | 17. Father's Name (First, Middle, Last) EDWARD VERNON MA | CTTM | | | | (First, Middle, Ma | , | |
| Z | d 2 should be th and Menta ?7 is marked of traumatic ev | P | 19a. Informant's Name/Relationship (| | 19b. N | failing Address (Street | | LEANOR CH | ASE Dity or Town, State, Zip | Code |
| | d 2 h a 7 is | | GEORGANN L. MASTI | N/WIFE | | | | | Y, MD 21801 | |
| Baltimore, | of He | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ | Domoval from State | 20b. Place of D | isposition (Name of crematory or other place | ce) | | c. Location - City or To | |
| Ē | t. Pages thent of I tant: If Ite | | 4 ☐ Donation 5 ☐ Other (Specify |) | CHESAPI | EAKE CREMAT | | 2/7/2008 | STEVENSVII | LLE, MD |
| Ба | permit. Page Department of Important: If any injury or once. | | 21. Signature of Funeral Prvice Licen | cam III | CFSP. | 22. Name and Addre FELLOWS, H 200 S. HAR | ss of Facility IELFENBEIN RISON ST | I & NEWNAL | M FUNERAL E | HOME PA |
| | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only | olications that caused to one cause on each line | the death. Do not e. | enter the mode of dyir | ng, such as cardiac o | or respiratory arres | , | Approximate Interval Between |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | aASCVI)_ | | | | | | Onset and Death |
| | Examiner | | | Due to (or as a | consequence of) | | | | | |
| | | Jer | Sequentially list conditions, if any, leading to immediate | b. — Due to (or as a | consequence of) | | | | | |
| | ecutec ind transi | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | | | | | 2.5 | |
| δĊ, | rificate be executed ig physician and as the burial-transit | | resulting in death) Last | Due to (or as a | consequence of) | | | | | |
| 68/60, | tificate ig phys as the | edical | | d | | | | | | |
| XOD | h certi | | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome p | | оПе | | | 23d. Date of delive | ry |
| | t the death by the atten ached for u | Physician/N | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1□Live birth 2 4□Pregnant at t 9□Unknown | | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) | | | Month | Day Year |
| <u>'</u> | requires that the | by P | Part II. Other significant conditions of | ontributing to death but | t not resulting in th | e underlying cause giv | en in Part I. | | cco use contribute to th | e cause of death? |
| cords | requi | eted | | | | | | 1 ☐ Yes | 2 x No 3 Prob | ably 4 □Unknown |
| Ě | To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use | Completed | | | | | | 24a. Was an autopsy performe 1☐ Yes 2 x | d? prior to con death? | osy findings available inpletion of cause of 2 X No |
| VItal | siciar certif irector | Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No | Hospital: | | otiont 2000 Othe | 26. Place of Death | | | |
| 5 | g Phy er this eral d | <u>ان</u> کو | 27. Manner of Death | 1 ☐ Inpatien 28a. Date of Injury | / 28b. Tim | e of 28c. Injur | 4 LI Nursing Hor | me 5 Lightesidence 128d. Describe how | e 6 Other (Specify |) |
| 202 | ath. or: Aft | atio | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day | Year) Inju | | k? Yes 2 □ No | | . , | |
| 200 | tal or Atters as after de al Directo | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of injur building, etc. | y - At home, farm, (Specify) | street, factory, office | 2 | 28f. Location (Stree City or Town, S | et and Number or Rura State) | Route Number, |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, to the funeral director. | Medical (| 29a. Certifier (Check only one) 1 Certifying Phyone 2 Medical Example 1 | rsician: To the best of iner: On the basis of and manner state | examination and/o | eath occurred at the tir or investigation, in my o | ne, date and place, a pinion, death occurr | and due to the caused at the time, date | se(s) and manner as st a and place, and due to | ated. the cause(s) |
| | To t withi To tl | Ž | 29b. Signature and title of certifier | <u> </u> | | 29c. Licenso | | | Date signed (Month, L | |
| ()- | - 1 1 | | Nether | | | | 7044 | | 2/5/08 | |
| 15 | TIVA | | 30. Name and address of person who o | ompleted cause of dea | ath (Item 23a) (Ty | pe, Print) | B 50 | lishan | 2/5/08 MD 21804 | |
| | Stat Registra | - | 31. Date filed (Month, Day, Year) | | 's Signature | 1 4 | | | ا حواله | |
| | 0.1-1.11-1(1) | | LLU (1. K. /// | in Plan | | Tariha B | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year Ernest McLeod 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Wicomico Rehab+ Nursim nlisburg If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth Sept 3, 1918 5. Social Security Number 7. Age (In frs. last birthday Birthplace (State or Foreign Country) **Funeral** Days **X**□M 2□F 221-18-7012 89 Director Jamaica Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director MD Wicomico Mardela Springs 1¥ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1 Funeral 9568 Athol Rd. 21837 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, et permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Black "natural", or 1 ☐ Yes 2 No Specify: Maryland 21215-0036 ģ Specify 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Manufacturing Laborer 6 Injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur McLeod Angelina Bryan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria L. McLeod/daughter 9568 Athol Rd., Mardela Springs, MD 21837 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Green Acres Mem Park 02/09/2008 Salisbury, MD 21. Sig ture of Fundal Service Line see 22. Name and Address of Facility Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cau e on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Oa-20134 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dus to for as a consequence of The law requires that the death certificate be executed I physician and is the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has b irector, page 2 s performed 1□ Yes 2 1 No the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Universing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ N6 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury To the Hospital or Attendii within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

lliam H.

FEB 0 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KODINS, M. D

32 Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Sa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 14:05P^M 4, 2008 4c. County of Death Mary Ann Martin /Medical February 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 640 Mecklenburg Avenue
Social Security Number 6. Sex Easton der 1 Year If Under 24 Hrs Apt. Talbot 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 5 F Months Hours 216-18-7587 83 Director June 23. 1924 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location , or Items 23s or 28s-f show 10d. Inside City Limits the Medical Examiner must be notified at Director MD Talbot 1 Yes 2 No Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 640 Mecklenburg Funeral 320 21601 Avenue Apt. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ☐ Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: þ Specify: White 3 ₩ Widowed 4 Divorced Year or Dates "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Telephone Operator Communications 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be life Depertment of Health and Mental Hy Important: If Itam 27 is marked oth any liquy or other traumatic event 90st. 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Swayko Helen Vajeor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul Douglas Martin, Jr. (Son) 304 Woodduck Court, Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) R.A.Ferris & Co., Ind 02/09/2008 West Chester, PA 22. Name and Address of Facility Zellman Funeral Home, P.A. Gignature of Funeral Service Licensee 123 S. Washington St., Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ARTERIOSCIEROTUS CANDIOVASCULAR DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or): Examine anding physicien and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? jo Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown peed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1 Yes 2 No of Vital ours after death.

Interest Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient To Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Medical Certification: 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Naturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital • Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29s. Certifier within 24 hou To the Fune completely file and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) hut Tallie gom me 10051408

DHMH 17 Rev 1/2001

State

Registrar

MICHABLS

31

30. Name and adgress of person who completed cause of death (Item 23a) (Type, Print)

2008

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32. Figistrar's Signature

S. Masoi

Year) 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 Decedent's Name (First, Middle, Last)
 Mary Nell Michaels 2. Date of Death Time of Death Physician Feb 14 2008 Day 12:15 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert. Prince Frederick 312 Dresser Ave. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | A | Months | Mo 7. Age (In yrs. last birthday 5. Social Security Number 6. Sex Birthplace (State or Foreign **Funeral** 551-40-0197 1 □ M 2 🗙 F Alabate Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location and Mental Hygiene.
and Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show
raumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Calvert. Prince Frederick 1 ☐ Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? with 1 20678 312 Dresser Ave. United States Funeral death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify þ Specify 3 ☐ Widowed 4 ♣ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) private club waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ruth Unknown Finch Unknown ပ other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 Dresser Ave. Prince Frederick, MD 20678 19a. Informant's Name/Relationship (Type. Print) Camille Morgan-daughter of Health a 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 15 2008 ate Metropolitan Funeral Service 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot Alexandria Virginia 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee 4405 Broomes Is. rd. Part Republic, MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Remorentoned Right Cancer **Physician** /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed sician and burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the nse 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atten detached for u 3 Ectopic pregnancy in the pest 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Tes 1 🔲 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Certification: **→** Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) FEB 2 1

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nayantara Memberca, MD 110 Hospital Drive Suite 310 Prince Frederick MD 20678 5

32. Registrar's Signature

Merdono

2008

20060638

2/15/08

| | | 1 - State of Maryland / Dep Registrar State of Maryland / Dep | artment of Health and M rtificate of Death | Mental Hygiene 008 | 05162 |
|---|-------------------------------|--|---|---|--|
| Physici | ion | 1. Decedent's Name (First, Middle, Last) | <u> </u> | Date of Death Month Day Year | 3. Time of Death |
| /Medi Examir | cal | Rachel Elizabeth Niemyer 4a. Facllity Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | February 8 2008 | 13:26P ^M |
| | | Washington County Hospital | Hagerstown | | on County |
| Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 M 2 F 93 Yrs. | | 8. Date of Birth 9. Birth (Month, Day, Year) Coo | nplace (State or Foreign untry) ryland |
| Maryland a-f show | ctor | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li Maryland Washington Ha | ocation gerstown_ | | 10d. Inside City Limits 1 □ Yes 2 🎇 No |
| with the a or 28 t be not | Dire | 10e. Street and Number 21766 Leithersburg-Smithsburg Road | 10f. Zip Code 21742 | 10g. Citizen of What Cou | , |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Iniportant: If fem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Completed by Funeral Director | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No | Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto | ecify Yes or No- Rican, etc.) 14. Race - Amer Black, White | rican Indian, e, etc. |
| ed within 72 hours af /giene. er than "natural", or t, the Medical Exam | eted by | 3 LAWidowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Dece | 1 Yes 2 No Specify: dent's Usual Occupation be kind of work done during most of work DO NOT use retired) | Specify: Wh | |
| d within giene. rr than ' | dmo | Elementary/Secondary (0-12) College (1-4or 5+) | Homemaker | | Residence |
| nd 2 should be file lith and Mental Hyy 27 is marked othe r traumatic event, | To Be C | 17. Father's Name (<i>First, Middle, Last</i>) Amos E. Bowman | | e (First, Middle, Maiden Surname) B. Bachtell Bowman | |
| d 2 shouth and No. | | | | al Route Number, City or Town, State, Zi thsburg Rd. Hagers | |
| permit. Pages 1 and Department of Heali Mportant: If item 2 Inty injury or other once. | | 20a. Method of Disposition 20b. Place of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State | osition (Name of matory or other place) | Date 20c. Location - City or T | Γown, State |
| permit. Pa Departmer Important: any Injury once. | | | urg Cemetery $2-12$ 2. Name and Address of Facility 0 | -08 Smithsburg Duglas A. Fiery Fun | |
| 9 9 E E 9 | | 23a. Part1. Enter the lisease, or condications the caused be death. Do not en shock, or he had failure. List only one cause the each line. | 1331 Eastern Blvd. | N. Hagerstown Mar | yland 2174: Approximate Interval Between |
| Physician /Medical Examiner | I Examiner | Immediate Cause (Final disease or condition resulting in death) Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): | a cuies po | enal Effusion | Onset and Death |
| The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Physician/Medical | | □Ectopic pregnancy □ Other (specify) | 23d. Date of delive Month | very Day Year |
| w requires that been signed to should be dete | by | Part II. Other significant conditions contributing to death but not resulting in the u | nderlying cause given in Part I. | 23e. Did tobacco use contribute to 1 ☐ Yes 2 ☐ No 3 ☐ Pro | |
| | Completed | els age | | autopsy prior to co performed? death? | topsy findings available ompletion of cause of |
| yslcian: The is certificate director, pag | o Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ PER/Outpatier | 26. Place of Death | n <i>(Check only one)</i> me 5 ☐ Residence 6 ☐ Other <i>(Spec.</i> | |
| ding Ph n. After th funeral | Certification: T | 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28b. Time of Injury 28b. | f 28c. Injury at Work? M 1 Yes 2 No | 28d. Describe how injury occurred 28f. Location (Street and Number or Rur City or Town, State) | |
| Hospitai 4 hours a Funeral I tely filled | ical | 29a. Certifier (Check only one) 1 | vestigation, in my opinion, death occurr | and due to the cause(s) and manner as red at the time, date and place, and due | to the cause(s) |
| To the within 2 To the complet | Mec | and manner stated. 29b. Signature and title of coefficier White Lower Completed cause of death (Item 23a) (Type, Flancisco Andrews 357 MILL 31. Date filed (Month, Day, Year) FEB 1 2 2008 | 29c. License number | 29d. Date signed (Month) | , Day, Year) |
| H-2 | | 30. Name and address of person who completed cause of death (item 23a) (Type, FILANCISEO AND VIEWDE 350 MILL | Print) HAGERSTON | ONEID OH ON | |
| Sta Registra | te ar | 31. Date filed (Month, Day, Year) FEB 1 2 2008 32. Red strar's Signature | Juli | | |

DHMH 17 Rev 1/2001

08-00792 John Smiley Nash

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| hn Smiley Nas | 1 | - For State | State | of Maryland | | rtment of tificate of | | ina ivieni | ai Hygie | ne Reg. | No. | 200 | 8 05 | 16 |
|--|----------------|---|---------------------------------------|--|----------------------------|--|------------------------------------|---------------------------|----------------------------|--|--------------|---------------------------|--------------------------------|----------|
| Physicia | n/ | legistrar 1. Decedent's Name (I | | est) | | <u> </u> | | | | nte of Death onth Death nuary 29, | ay Y | Year | 3. Time of Death 0748 hrs | |
| edical Examir | | JOHN S. 4a. Facility Name (if n | | ive street and number) | 1 | | 4b. City, Town, | or Location o | | nuary 29, | | ity of Death | | \neg |
| A. | | 200 Harper Je | | | | | Centrevill | | Io | and the state of t | | n Anne's | place (State or | |
| Funeral Director | | 5. Social Security Nur 195–46–53 | | Sex 7. Ag | je (In yrs. Ia | st birthday) Yrs | | ear If Unde Days Hours | Min. | AN 28, | | Foreign | ntry) PA | |
| any | - | Usual Residence of D 10a. State 10 | b. County | | 10c. City, | Town or Locat | ion | | | | | | 10d. Inside City Li | _ |
| <u> </u> | ٦ | MD | QUEEN A | ANNE'S | | CENTRE | VILLE | | | | | | 1 Yes 2 X | No |
| Maryland 28a-f show d at once. | Director | 10e. Street and Numb | er | | | | 10f. Zip Cod | е | | 10g | . Citizen of | What Coun | try? | |
| ith the 23a or notifie | | 200 HAR | PER JES | 12. Was Deceden | t Ever in II. | S 13 Wa | as Decedent of | 21617 Hispanic Ori | gin? (Specify | Yes or No- | 14. R | USA ace - Americ | can Indian, Black, | |
| eath wittems | Funeral | 1 Never Married | 2 Marrie | ed Armed Forces | | If Y | es, specify Cu | ban, Mexicar | , Puerto Rica | n, etc.) | l w | /hite, etc. | | |
| after d | by Fi | 3 Widowed | | ed If Yes, Give Year | | 1 | - | | _ | dano | | f Business/Ir | | |
| hours "natur Exam | | 15. Decedent's Educ | | only highest grade co | | 16a. Deceder during n | nt's Usual Occu nost of working | life. DO NOT | use retired) | one | TOD. KING O | Dasiness/ii | idosti y | |
| 336 thin 72 ne. ' than ' | mpleted | 12 | July (0 12) | 0 | , | FA | RMER | | | | | RICULT | URE | |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shi injury or other traumatic event, the Medical Examiner must be notified at once | ပ္ပို | 17. Father's Name (F | | | | | | 1 | r's Name (Firs | | aiden Surna | ame) | | |
| 2121 2121 wild be f Mental market c event | To Be | CHARLES 19a. Informant's Nam | | | | 19b. Mailin | g Address (S | | NE GES mber or Rural | | er, City or | Town, State | , Zip Code) | |
| MD 2 d 2 shou Ith and I n 27 is 1 | | | | NUM/SISTER | | | | | | | CORL | OVA, | MD 21625 | |
| re, rest the alt | Ī | 20a. Method of Dispo | | 3 Removal from S | state | crematory or o | | | Da | | | | Town, State | |
| Baltimore, permit. Pages I an Department of Hee Important: If ite | | 4 Donation 5 | Other Spec | ify: | СН | | Name and Add | | | 31/20 | 8 STE | EVENSV | ILLE, MD | |
| Balt permit. Depart Impor injury | | 21. Signature of Fund | | ensee SERCER | | . 11 | ELLOWS 200 S. | , HELF | ENBEIN | & NEV | NAM E | UNERA 21601 | L HOME P. | Å |
| Physician | | | disease, or co | mplications that cause | d the death | . Do not enter | the mode of dy | ing, such as | cardiac or res | piratory arre | st, shock, o | or heart | Approximate In Between Onse | |
| 'Medical aminer | 9 4 | failure. List only Immediate Cause (F | inal disease | a. Contact Gunsh | | | | | | | | | Death | |
| | | or condition resulting | | Due to (or as a con | sequence o | of): | | | | | | | | |
| | īē | Sequentially list condition if any, leading to immediate. Enter Under | nediate | Due to (or as a con | sequence o | of): | | | | | | | | |
| | Examiner | (Disease or injury the events resulting in d | at initiated | Due to (or as a con | sequence o | of): | | | | | | | | |
| executed ian and al - transi | al E | | · · · · · · · · · · · · · · · · · · · | d | | | | | | | | | | |
| 60, e be executed ysician and burial - transit | ledical | UNPENDED | | AMENDED | ome of prov | mancy | | | _ | | 23d. Da | ate of deliver | <u> </u> | |
| ox 6876(eath certificate attending phy | Physician/M | IF FEMALE: 23b. Was decedent p past 12 months? | | 23c. If yes, outc | | 2 F | etal death | | ic pregnancy | | Mor | nth | Day Yea | ar |
| Box 6876 death certificat the attending physical for use as the | sici | 1 Yes 2 N | | - | at time of d | eath 5 (| Other (Specify) | | | | 1 | | | |
| that the d | | Part II. Other signif | icant conditio | ns contributing to de | ath but not | resulting in the | underlying ca | use given in l | Part I. | | - | | the cause of dea | |
| r, P.O ires that t signed by | d by | | | | | | | <u></u> | | 1 Yes | | | utopsy findings av | _ |
| ords, w requir as been s | Completed | | | | | | | | | autop | | | completion of cau | |
| tal Rectains The la | Som | | | | | | - 00 | Disease of Descri | h (Chaok only | 1 🗸 Yes | | 1 🗸 Y | es 2 | No |
| ital Fician: Secrific | Be | 25. Was case referre examiner? | | Hospital: 1 Inpa | itient 2 | ER/Outpatie | | Other | h (Check only Nursing H | | Residence | 6 🗸 Oth | er: Scene | |
| ing Phys After this funeral di | 7 | 1 ✓ Yes 2 27. Manner of Death | 2 No | 28a. Date of I | niurv | 28b. Time o | | . Injury at Wo | ork? 28 | d. Describe ibject sho | now injury o | occurred | | |
| ion tendiin eath. Iort A | atior | 1 Natural 2 Accident | 5 Pendin | gation | | 0735 hrs | 1 | Yes 2 | No | | | V | Doute Number | or City |
| Division of Vital Records, ral or Attending Physician: The law requir rs after death. The The The The The The Institute has been seled in by the funeral director, page 2 should t | Certification: | 3 V Suicide | 6 Could | not be 28e. Place of | | | reet, factory, of | ffice building, | | f. Location () or Town, S O Harper Je | itate) | | Rural Route Numbe | si, Gily |
| Division Bospital or Attend Abours after death Funeral Directors stely filled in by the | | 4 Homicide 29a. Certifier | Contifuing Phys | raining. To the heat of | my knowle | dge death occ | curred at the tir | ne, date and | place, and du | e to the caus | e(s) and m | nanner as sta | ated. | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri | Medical | (Check only one) 2 | Medical Exam | iner: On the basis of e | xamination | and/or investig | gation, in my o | pinion, death | occurred at th | ne time, date | and place, | and due to | tne cause(s) | |
| T is a so | Me | 29b. Signature and | title of certifier | Granding State | | | | icense numb | er | | | e signed (M ry 30, 206 | lonth, Day, Year) | |
| | | Janule & | outhan | (m) | | | | D.C.M.E. | | | Janual | ı y 50, 201 | | |
| | | 30. Name and address | | who completed cause of Assistant Me | of death (Ite edical Ex | _{m 23a)} aminer - 1 | I11 Penn S | treet, Balt | imore, MD | 21201 | | | | |
| | tate | | | - | strar's Sign | | 27 | | | | | | | |
| Regis | | FE | DATE | UUU JEEN | ע היו | A STATE OF THE STA | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 3:55 A M 3, ROGER **EDWARD** O'CONNOR February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Days Hours Min. 85 Dec. 9, Director 046-14-5274 1922 Connecticut Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Director Maryland Frederick Walkersville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 2810 Raleigh Road 21793 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after or and Mental Hygiene. 1∑Yes 2☐No If Yes, Give Year or Dates: WWII 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No þ Specify: 3 ₩idowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Purchasing Agent Airpax Corporation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Joseph O'Connor Irene Giguere 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 si Department of Health an Important: If item 27 is r any Injury or other traur Carole Turner/ Daughter 244 Oakridge Dr. Marquette Michigan 49855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/8/2008 Glade Cemetery Walkersville, Maryland 21. Signature of uneral Service 22. Name and Address of Facility Stauffer Funeraĺ 1621 Opossumtown Homes Pike, P. A. Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) latera **Physician** meumonia /Medical Due to (or as a consequence of): Examiner thymidism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last of (or as a consequence of): Examine burial-tran Due to (or as a consequence of): attending physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the 9□Unknown 9 Unknown been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 npatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in here. 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

be executed Box 68760 P.0. Division or Vital Records,

Maryland 21215-0036

Baltimore,

State Registrar

Medical

ariuna

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

D0065443

08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Elena Iarikova MD 400 West 7th Street, Frederick, Maryland 21701

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only



| | | For | lease Type or Pri State of M | | Department of | Health and M | _ | | egible. | DELCE |
|---|-------------------|---|--|------------------------------------|---|---|---------------------------------------|-------------------------------|------------------------------------|--|
| | | 1 - State Registrar | | | Certificate of | f Death | , | Reg. No. | UUÖ | 00100 |
| Physici | an | 1. Decedent's Name (First, M | | | | | 2. Date of De Month | eath Day | Year | 3. Time of Death |
| /Medic | cal | | len Oden | | Ab City Town | and another of Denth | 02 | 04 | 2008 | 2100 PM |
| Examir | er | (1) | tution, give street and number) Glonal Media 6. Sex 7. Ac | al Cent | er sa | or Location of Death Old Share at 1 of Under 24 Hrs. | | 1 | ounty of Death | ace (State or Foreign |
| Funeral Director | | 213–42–1807 Usual Residence of Deceden | 1 □ M 2 ∑ F | | Yrs. Months Day | | 8. Date of Bi (Month, Di 1/21/1 | ay, Year) 942 | Count | rland |
| ryland how | _ | 10a. State 10b. Co | ounty | 10c. City, Tow | n or Location | | | | 10 | Od. Inside City Limits |
| th the Marylar or 28a-f show e notified at | Director | - 2 | licomico | Sal: | isbury | | | | | 1 X Yes 2 No |
| filed within 72 hours after death with the Maryland Hygiene. Hygiene, then "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at | | 10e. Street and Number 400A Park A | | | 10f. Zip Code 2180 |)1 | | US | | |
| er des items ner m | Funeral | 11. Marital Status | 12. Was Decedent Armed Forces? | | 13. Was Decedent of If Yes, specify Cu | f Hispanic Origin? (Sp Jban, Mexican, Puerto | ecify Yes or No Rican, etc.) | 0- 14. | Race - America Black, White, e | |
| urs aff | þ | 1 ☐ Never Married 2 ☐ 3 🛣 Widowed 4 ☐ Divo | If Yes Give | NO | 1 ☐ Yes 2 🙀 N | o Specify: | | Sp | pecify: wh: | ite |
| 72 hou | ted | 15. Dece | edent's Education nighest grade completed) | | Decedent's Usual Occ | upation | | 16b. Kind | of Business/Ind | ustry |
| within 7 jiene. r than "r the Med | Completed | Elementary/Secondary (0- | | 5+) | (Give kind of work don life. DO NOT use retii financial a | | ang | Sali | .sbury U | niversity |
| e filec al Hyg othe | Bec | 17. Father's Name (First, Mic | ddle, Last) | | | 18. Mother's Nam | | | | |
| ould b Ment arked atic e | 70 | Earcy Kline | | | | | Irene B | | | |
| permit. Pages 1 and 2 should be filled within 72 hours after death with the Man Department of Health and Mental Hygiene. Inportant: I item 27 is marked other than "natural", or items 23a or 28a-1 sh any injury or other traumatic event, the Medical Examiner must be notified. | | | tionship (<i>Type. Print</i>) niflet/daughter | | . Mailing Address (Stree 4371 Tyaski | et and Number or Rui n Rd., Tya | askin, | MD 21 | own, State, Zip .865 | Code) |
| ges 1 It of H If iter or oth | | 20a. Method of Disposition 1 ☐ Burial 2 【▼ Cremat | tion 3 □Removal from State | cemete | f Disposition (Name of ry, crematory or other p | lace) | Date | | ion - City or To | |
| iit. Pa artmer ortant: njury | | 4 □ Donation 5 □ Othe 1 Signature of Funeral Ser | | Salisb | oury Cremato | | | | sbury, 1 | |
| perm Depa Impo any i | | Signature of Pulleral Ser | (Bompson | CFSP | #HOTTOWA 501 Sno | y Funeral w Hill Rd. | Home Pr | cofess. | ional A MD 218 | ssociation 04 |
| Physician /Medical Examiner | | 23a. Part1. Enter the diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) | e, or complications that cause List only one cause on each li a | d the death. Do r | not enter the mode of d | | or respiratory a | | | Approximate Interval Between Onset and Death |
| 4 | ler | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as | a surisequense: | | 100 | | | | |
| be executed sician and burial-transit | al Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | | a consequence | of): | | | | | |
| ifficate g phys as the | edic | | d | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death, within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the b | Physician/Medical | IF FEMALE: 23b. Was decedent pregnan: in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | | 2 Fetal death | 3 □Ectopic pregnan 5 □ Other (specify) | ncy | | 23d | . Date of deliver Month | y Day Year |
| s that in the property of the | | Part II. Other significant con | nditions contributing to death b | ut not resulting in | the underlying cause g | jiven in Part I. | 23e. Did | tobacco use | contribute to the | e cause of death? |
| quires en sign | ed by | | | | | | 1 🗆 | Yes 2□ N | No 3 ☐ Proba | ably 4 Unknown |
| The law re te has bee age 2 sho | Completed | | | | | | | opsy ormed2 | prior to con death? | sy findings available apletion of cause of |
| ilan: ertifica ctor, p | BeC | 25. Was case referred to me examiner? | edical | | | 26. Place of Deat | 1 Yes h (Check only | one) | 1 □ Yes | 2 □ No |
| hysic this ce | 2 | 1 □ Yes 2 No | Hospital: 1 Inpatie | | tpatient 3 DOA | ther: 4 Nursing Ho | me 5□Res | idence 6 | Other (Specify |) |
| ing P | ion: | 27. Manner of Death 1 Natural 5 □ Pe | | | rime of 28c. Inj njury W | | 28d. Describe | how injury o | ccurred | |
| To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. | Certification: | 3 Suicide 6 □ Co | | ury - At home, fai c. (Specify) | M 1[rm, street, factory, office | Yes 2 No | 28f. Location (City or To | (Street and N wn, State) | lumber or Rural | Route Number, |
| e Hospit: 24 hours e Funera letely fille | Medical C | 29a. Certifier 1X Cert (Check only 2 Med | tifying Physician: To the best lical Examiner: On the basis o and manner sta | f examination an | e, death occurred at the d/or investigation, in my | time, date and place, opinion, death occur | and due to the | cause(s) an , date and pla | d manner as sta ace, and due to | ated. the cause(s) |
| To the vithin To the compl | Me | 29b. Signature and title of cer | rtifier | | | nse number | | | igned (Month, L | Day, Year) |
| 1 (0) | | 11 1/2 | ~ | | H5 | 4827 | | 2 | 1510 | 8 |
| D An | | 30. Name and address of per | rson who completed cause of d | eath (item 23a) (| Type, Print) 3/4/3 | 4827 Ninterplace | C PKM | 394 | sbyn . | MO |
| Sta | | 31. Date filed (Month, Day, Y | | ar's Signature | Beartes. | - pp | | • | | |

| Projection Pro | | | | 1 - For State Registrar | State of Ma | aryland | | irtmen <i>tificat</i> i | | | and M | | giene Reg. No. | 200 | 8 05 | 5166 |
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| Statistics of Control of December 2 40 CBs, 1 Cast of December 3 40 CBs, 1 | | | | | ŕ | sner | | | | | | Month | Day | | 11 | |
| Prince P | | | | 4a. Facility Name (If not institution, | give street and number) | | | 4b. City, | Town, or | Location o | | | | | | |
| Discretion Total 200 For the Company For | | | | Suburban | Hospital | | | | | | | | | Mont | gomery | |
| Silver Spring 100. Forest Chip. Tower and Austrean 100. Forest Chip. Tower and Tower 100. Forest Chip. Tower 100. Forest Chip. Tower and Tower 100. Forest Chip. Tower | 00 | | | | | | | | | | Min. | 8. Date of Birt (Month, Day December | h /, Year) 28 ,1 9 | (| Co <i>untry</i>) | |
| Fred Raitano Fr | 20 | and w | | | | 10c. City. | Town or Lo | cation | | | | | | | 10d Inside | City Limits |
| Fred Raitano Fr | 7. 3 | // // // // // // // // // // // // // | 5 | | | , | | | 0 * 1 | | | | | | | |
| The first Name (First, Middle, Last) Fred Raitano Fred R | 00 | 15 28a | rec | | gomery | | | | | r spri | ng | | 10g. Citize | en of What (| Country? | |
| The first Name (First, Middle, Last) Fred Raitano Fred R | 1 | 3a or | | 2620 Shanand | ale Drive | | | | | 20904 | | | | II. S | S. A. | |
| The first Name (First, Middle, Last) Fred Raitano Fred R | 0 | deatl | ner | | 12. Was Decedent E | Ever in U.S | | Vas Deced | lent of Hi | spanic Orig | gin? (Spe | cify Yes or No- | . 14 | I. Race - An | nerican Indian, | |
| Fred Raitano Fr | S714 | urs after al", or Ite Exa⊓ine | | | ed 1 ☐ Yes 2 ☑ N If Yes, Give | No | | | | | i, rueito i | nicari, etc.) | 8 | | | |
| The first Name (First, Middle, Last) Fred Raitano Fred R | 2-0 | 72 ho natur Ilcal | sted | 15. Decedent's | s Education | | 16a. Deced | lent's Usua | l Occupa | ation | t of workir | 20 | 16b. Kind | of Busines | s/Industry | |
| The first Name (First, Middle, Last) Fred Raitano Fred R | 72 | /ithin ne. han " | ם | | College (1-4or 5- | +) | | | | | | .5 | | | | |
| Physician Medical Examiner Physician Medical Examiner Physician Medical Physician Physician Medical Physician Physician Medical Physician Physician Physician Medical Physician Physician Medical Physician P | | lled w Hygie ther th | S | 17 Father's Name (First Middle I | | | Elec | cted 0 | ffici | | r's Namo | /Eirst Middle | | | County, | MD |
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| Physician Medical Examiner Physician Medical Examiner Physician Medical Physician Medical Examiner Physician Medical Physician M | 7 | should Me Thairly | ř | | ip (Type, Print) | | 19b. Mailin | g Address | (Street a | and Numbe | | | er. City or | Town. State | . Zip Code) | |
| Physician Medical Examiner Physician Medical Examiner Physician Medical Physician Physician Medical Physician Physician Medical Physician Physician Physician Medical Physician Physician Medical Physician P | ~ ≅ | nd 2 sailth an 27 is r trau | | Donald E. Praisner | r - Spouse | | 2620 |) Shan | andal | e Driv | e. Si | lver Spri | ng. M | arvland | 20904 | |
| Physician Medical Examiner Physician Medical Examiner Physician Medical Physician Medical Examiner Physician Medical Physician M | G. | is 1 a of Hear item | | 20a. Method of Disposition | | 20b. Pla | ace of Dispo | sition (Nan | ne of | 1 | | | | | | |
| Physician Medical Examiner Physician Medical Examiner Physician Medical Physician Medical Examiner Physician Medical Physician M | J.E | Page nent c int: If | | | | | | | | | 02/06 | /2008 | Silve | r Spri | ng, Maryl | land |
| Physician (Medical Examiner) Physic | Balti | permit. Departn Imports any inju | | 21. Signature of Funeral Service L | icens CR 45 | ~ | H: | ines-R | inald: | i Fune | ral Ho | | | ring N | lary land | 2090/ |
| Physician (Medical Examiner) Physician (Medical Examiner) | | | | 23a. Part1. Enter the disease, or o | complications that caused | the death. | | | | | | | | Ling | | |
| The purpose of the | | Physician | | Immediate Cause (Final | | | om Omeson | Post 1 | 1200 | | | | | | Onset an | d Death |
| Squantially list conditions, the part of t | 3 | /Medical | | resulting in death) | | | | I rall | пе | | | | | | 40 110 | uis |
| Cause: Enter Underlying Cause: Decease or injury resulting in death) Last Co. Aortic Valve Stenosis Co. Aortic Valve Stenosis Co. Aortic Valve Stenosis Co. Aortic Valve Stenosis Due to (or as a consequence of): Co. Aortic Valve Stenosis Co. Aor | 0 | 10 page | | Sequentially list conditions | U | | ********** | 3 | | | | | | | Year | s |
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| The color of the | | ecute and I-trans | хаш | that initiated events resulting in death) Last | 0. | | | 3 | | | | | | | Year | S |
| FERMALE: 23b. Was decedent pregnant in the past 12 months? 1 1 2 28 No 9 Unknown 1 1 28 28 No 9 Unknown 1 28 28 No 9 Unknown 29 Unknown 20 1 28 28 No 9 Unknown 20 28 28 No 9 Unknown 20 28 28 No 9 Unknown 20 28 28 No 28 No 28 No 28 | ,09 | be es | alE | | | | 0.1,0 | | | | | | | | | |
| Females Color Co | 687 | ficate p phys is the | edic | | d | | | | | | | | | | | |
| Status Post Mitral & Aortic Valve Replacement 1 Yes 2 No 3 Probably 4 Unknown | ŏ | attending for use a | ian/M | 23b. Was decedent pregnant in the past 12 months? | 1 ☐Live birth | 2 🗌 Fetal (| death 3□ | | | | | | 23 | | , | Year |
| Status Post Mitral & Aortic Valve Replacement 1 Yes 2 No 3 Probably 4 Unknown | | the d y the | ysi | | | timo or go | uu | router (op | JUNY | | | | | | | |
| RyperCents 100 | iξ. | s that ned b deta | y Pr | Part II. Other significant condition | າຣ contributing to death bu | ıt not result | ting in the ur | derlying ca | use give | n in Part I. | | 23e. Did to | bacco us | e contribute | to the cause o | f death? |
| Ryper Certifier 1 Yes 2 No Number or Rural Route Number, State) 1 Yes 2 No Number or Rural Route Number, State) 1 Yes 2 No Number or Rural Route Number, State) 1 Yes 2 No Number or Rural Route Number, State) 1 Yes 2 No Number or Rural Route Number, State 1 Yes 2 No Number or Rural Route Number, State 1 Yes 2 No Number or Rural Route Number, State 1 Yes 2 No Number or Rural Route Number, State 1 Yes 2 No Number or Rural Route Number, State 1 Yes 2 No Number or Rural Route Number, State 1 Yes 2 No Number or Rural Route Number, State 1 Yes 2 No Number or Rural Route Number, State 1 Yes 2 No Number or Rural Route Number, State 1 Yes 2 No Number or Rural Route Number, State 1 Yes 2 No Number or Rural Route Number, State Number or Rural Route Numbe | rds | quire en sig uld b | q pe | Status Post Mitra | l & Aortic Valv | e Repl | Lacement | | | | | 1 🗆 Y | ′es 2. | No 3□ | Probably 4 [| □Unknown |
| 26. Place of Death (Check only one) 27. Was case referred to medical examiner? 28. Place of Death (Check only one) 28. Describe how injury occurred 28. Place of Death (Check only one) 28. Describe how injury occurred 28. Describe how injury occurred 28. Location (Street and Number or Rural Route Number, City or Town, State) 28. Describe how injury occurred 28. Location (Street and Number or Rural Route Number, City or Town, State) 298. Place of Injury M 1 Yes 2 No 289. Place of Injury At Work? 3 Suicide determined 280. Describe how injury occurred 281. Location (Street and Number or Rural Route Number, City or Town, State) 299. Signature and title of certifier 290. Date signed (Month, Day, Year) | 900 | aw re Is bee 2 sho | plet | Hypertension | | | | | | | | | | 24b. Were | autopsy finding | s available |
| 26. Place of Death (Check only one) 27. Was case referred to medical examiner? 28. Place of Death (Check only one) 28. Date of Death (Check only one) 28. Date of Injury of Death (Check only one) 28. Date of Death (Check only one) 28. Date of Injury of Death (Check only one) 28. Date of Injury of Death (Check only one) 28. Date of Death (Check only one) 28. Date of Injury of Death (Check only one) 28. Date of Death (Check only one) 28. Date of Injury of Death (Check only one) 28. Date of Death (Check only one) | | The I | mo | | | | | | | | | perfo | rmed? | death | ? . | I cause of |
| D0062283 February 1, 2008 | z ok /ita | clan: ertifica ctor, | | | | <u>.</u> | | | | | of Death | (Check only o | ne) | | | |
| D0062283 February 1, 2008 | | hysic this co | L _O L | 1 ☐ Yes 2 ☒ No | 1 🗵 Inpatier | | | | ^ | 4 🗆 Nu | | | | | ecify) | |
| D0062283 February 1, 2008 | | Ing F | ion: | 1 ☑ Natural 5 ☐ Pending | (Month, Day | | | | | | | 28d. Describe h | ow injury | occurred | | |
| D0062283 February 1, 2008 | Sici | death stor: | icati | 3 Suicide 6 Could no | ot be as Blood of injur | rv - At hom | ne farm stre | | | res 2 | | 98f Location (S | Street and | Numberor | Pural Poute Ni | umber |
| D0062283 February 1, 2008 | N | lor A after Direc | ertif | 4 ☐ Homicide determin | building, etc | . (Specify) |) | oci, lactory | , onice | | - | City or Ton | n, State) | ivuilibei oi | nulai noule ivi | umber, |
| D0062283 February 1, 2008 | _ | spita nours neral | S E | 29a. Certifier 1 ☑ Certifying | Physician: To the best o | of my know | rledge, death | occurred | at the tim | ne, date an | d place, a | and due to the | cause(s) a | ınd manner | as stated. | |
| D0062283 February 1, 2008 | | ne Ho 24 h ne Fui | dic | (Check only 2 Medical E one) | xaminer: On the basis of and manner sta | examination ted. | on and/or inv | estigation/ | in my op | oinion, dea | th occurre | ed at the time, | date and p | olace, and d | ue to the cause | e(s) |
| | | To the within To the comp | Me | 29b. Signature and title of certifier | _A | | | 290 | . License | number | | | 29d. Date | signed (Mo | nth, Day, Year, |) |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | 1. | | How | mill | | | | D006 | 2283 | | | Feb: | ruary 1 | , 2008 | |
| | | 9 | | | | | | | | | | | | | | |
| Keith Andrew Horvath, M.D., 8600 01d Georgetown Road, Bethesda, Maryland 20814 | | | | | | | | rgeto | n Roa | ad, Bet | thesda | a, Maryla | nd 20 | 814 | | |
| State Registrar FEB 0 6 2008 32. Distrar's Signature | | | | | 2008 32. gistra | u s oignatu | k A | and a | | | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year 6:20 DM Peter Pallme-Koenig 30 January 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 X M 2 □ F Yrs. Director 219-25-1880 66 September 7,1941 Germany Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits r 28a-f sh 1 ☐Yes 2 X No Directo Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or: any injury or other traumatic event, the Medical Examiner must be n 9204 Bluebird Terrace 20879 Germany Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: \$ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Field Engineer Electrical Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Einhardt Pallme-Koenig Hildegard Ardelt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Pallme-Koenig - Spouse 9204 Bluebird Terrace, Gaithersburg, Maryland 20879 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Fort Lincoln Crematory 02/11/2008 Brentwood, Maryland 21. Signature of Funer Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final disease or condition resulting in death) Aortic Stenosis 10 years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying 1998 that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed' 1∐ Yes 2 🗴 No

Physician /Medical Examiner

the Maryland

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital Records,

show

law requires that the death certificate be executed and burial-tra attending physician for use as the buria ed by the a After this certificate has been signed by funeral director, page 2 should be detacl this ie Hospital or Attending Pl 24 hours after death. ie Funeral Director; After ti filled in by the within 24 hours a

To the Funeral C

Be Certification: To

Completed

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☑ No

29a. Certifier

(Check only one)

27. Manner of Death 5 Pending 1 Natural investigation 2 Accident 3 ☐ Suicide 4 Homicide

6 Could not be determined

29b. Signature and title of certifier

28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 X ER/Outpatient 3 DOA

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

1 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D21340

29d. Date signed (Month, Day, Year) February 1, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 15225 Shady Grove Road, #302, Rockville, Maryland 20850 Raymond Bass,

1 Inpatient

State Registrar

completely

31. Date filed (Month, Day, Year) FEB 0 6 2008



DHMH 17 Rev 1/2001

3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month 1617 PM 62008 /Medical bruca Facility Name (If not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year)
2 09 1943 5. Social Security Number . Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours 1**X**]M 2□ F 65 216-40-4281 Director MD Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10a. State 10d. Inside City Limits MD Kent Chestertown 1 ☐ Yes ¾☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be n Caulkfield Rd 8528 21620 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married 1 □ Yes 2 No Specify Black Baltimore, Maryland 21215-0036 Specify: <u>م</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monce. College (1-4or 5+) Welder Chrysler Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward S. Perkins, Sr. Anna Hackett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8528 Caulkfield Rd Chestertown, MD 21620 Margaret Perkins-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State Asbury U.M. 2/16/08 4 □ Donation 5 □ Other (Specify) Chestertown, MD 22. Name and Address of Facility Kenneth Walley Funeral 21. Signature of Funeral Service Licensee 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Service 821 W. St. Annapolis, MD 21401 Immediate Cause (Final disease or condition resulting in death) **Physician** Henato Renal 4 days /Medical Examiner rv40513-End Sta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Sarcoid the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, ed by the attending physician detached for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No. 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by DIM Typotty HT105 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has the rector, page 2 s autopsy perforn 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 14 Inpatient 2 ER/Outpatient 3 DOA this (Certification: To funeral 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1X Natural 5 Pending investigation To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0050996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

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Registrar

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31. Date filed (Month, Day, Year)

Student

32. Registra Signature
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| | | | 1 = For State Registrar | State of Ma | iryiand | | artment of tificate of | | | 21 | 008 | 05169 |
|-------------|---|----------------|--|--|-------------------------|--------------------------------|--|--|---|---|---|--|
| | | | Decedent's Name (First, Middle, Last) | | | | | Boain | 2. Date of Dea | | | 3. Time of Death |
| 97 | Physici /Medic | | MARGARET E | | PHE | BUS | | | Month FEBRUAR | Day Y 12. | Year 2008 | 11:55A M |
| | Examir | | 4a. Facility Name (If not institution, give s | street and number) | | | 4b. City, Town, | or Location of Dea | _ | | unty of Death | 111.5511 |
| | | | Northhampton M | | | | | erick | | | reder | |
| i | Funeral Director | | 219-20-0834 | 7. Age | (In yrs. la | st birthday) Yrs. | Months Day | | | h y, <i>Year)</i> · 1910 | 9. Births Cour | place (State or Foreign ntry) MD |
| | land ow | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, | Town or Lo | cation | | | | 1 | 10d. Inside City Limits |
| | Mary -f sh fied a | to | MD Frederi | .ck | Fr | ederi | lck | | | | | 1 ☑ Yes 2 ☐ No |
| | h the | Director | 10e. Street and Number | 1 | | | 10f. Zip Code | | T | 10g. Citizen | of What Cour | ntry? |
| | ath wij | ra L | 750 Carroll Par | kway Ap | t 6- | С | 217 | 01 | | | USA | |
| 36 | be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or tiems 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 M N If Yes, Give Year or Dates: | | | Vas Decedent of f Yes, specify Cu I □ Yes 2X N | | Specify Yes or No- erto Rican, etc.) | | Race - Americ Black, White, ecify: W.h. | |
| 215-0036 | filed within 72 hou Hygiene. vther than "natura ent, the Medical E | Completed | 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) | cation | | 16a. Deced (Give life. L | lent's Usual Occ kind of work don OO NOT use retii | upation e during most of weed) | orking | 16b. Kind o | of Business/In | |
| 7 | ed with | Com | 10 | | <u> </u> | Н | ome Mak | er | | Own | Home | |
| g | be filed that Hygie of other sevent, the | Be (| 17. Father's Name (First, Middle, Last) | | | | | | ame (First, Middle, | | rname) | |
| <u>\</u> | 2 should be and Mental is marked aumatic ev | မှ | Benjamin Ellswo | | bus | | | | Burges | | | |
| Maryland 21 | 2 a is | | 19a. Informant's Name/Relationship (Type | | | | | | Rural Route Numbe | , | , | |
| <u>ئ</u> | s 1 and F Health tem 27 other tr | | Darlo Weddle F 20a. Method of Disposition | rrend/Po | | | wyngat sition (Name of natory or other pi | | Freder | | on - City or To | |
| Ē | D = D | | 1 □XBurial 2 □ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify) | emoval from State | Mou | | | 1 | 5/2008 | Frod | oriok | MD |
| galtimore, | permit. Pag Department Important: I any injury o | | 21. Signature of Funeral Service Lightness | ee | mou | | . Name and Add | | | | | , по Р.А. F.H. |
| מ | e m m | N A | John Lattle | m) M | 0117 | 6 10 |)6 East | | | | | MD 21701 |
| | Physician | | 23a. Part1 Enter the disease, or complication or heart failure. List only on Immediate Cause (Final disease or condition | | MA | Xen | 1/12 | ring, such as cardi | ac or respiratory ar | rest, | | Approximate Interval Between Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as a | orseque | nce of): | - 1 | 2115 | 20.0 | | | |
| | LXdiiiiiici | <u>_</u> | Sequentially list conditions, b | | | | IOU | gNENA | WIA | | / | 1-2 DAYS |
| Ţ | nsit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a | conseque | nice ory. | | | | | | |
| , , | execu n and ial-tra | Exa | that initiated events c. resulting in death) Last | Due to (or as a | conseque | nce of): | | <u></u> | | | | |
| 09/90 | tificate be executed g physician and as the burial-transit | edical | d | | | | | | | | | |
| _ | | | IF FEMALE: | | | | | | | | | |
| .C. BOX | The law requires that the death certificate has been signed by the attending page 2 should be detached for use as | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 3c. If yes, outcome p 1□Live birth 2 4□Pregnant at t 9□Unknown | Fetal d | leath 3 | Ectopic pregnan Other (specify) | су | | 23d. | Date of delive Month | ery Day Year |
| , , | s that ned by deta | by Ph | Part II. Other significant conditions con | - | | - | | | | bacco use d | contribute to the | he cause of death? |
| ğ | equires an sig ruld be | ed b | DEGENSMAT | IVE JU | LUT | 018 | FASE | BOTH | HIPS 1 Y | es 2 | lo 3□ Prob | oably 4 Unknown |
| Records, | law re as be 2 sho | Completed | | | | | | | 24a. Was a | | 4b. Were auto | psy findings available |
| E | The ate h | Som | | | | | | | perfor 1 Yes | med? | death? | mpletion of cause of 2 □ No |
| N 112 | cian: ertific | Be (| 25. Was case referred to medical examiner? | | | | | | eath Check onl of | - | | |
| 5 | Physi this c | 2 | I les Ziprio | ospital: | | | 3 DOA | ther: 4 Nursing | Home 5 ☐ Resid | | | y) |
| = | ding I. After funer | ion | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Injury (Month, Day | Year) | 8b. Time of Injury | 28c. Inj We M 1[| uryat ork? ⊒Yes 2.⊡No | 28d. Describe h | ow injury oc | curred | |
| DIVISION OF | after deatl after deatl I Director: d in by the | Certification: | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of injur building, etc. | y - At hom (Specify) | e, farm, stre | | | 28f. Location (S City or Tow | treet and Nun, State) | umber or Rura | al Route Number, |
| | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 to make the completely filled in by the funeral director, page 2 to make the completely filled in by the funeral director. | edicat | 29a. Certifier 1 Certifying Phys (Check only one) | ician: To the best of ner: On the basis of e and manner state | examinatio | edge, death n and/or inv | occurred at the estigation, in my | time, date and place opinion, death occ | ce, and due to the courred at the time, | cause(s) and date and pla | d manner as s ace, and due to | tated. the cause(s) |
| | To t To t | Ž | 29b. Signature and title of certifier | | | , . | | se number | I | | gned (Month, | 4 |
| | 00- | | · will | m | | MD | 0 | 2649 | 9 | 2-1 | 7-0 | 8 |
| | 9 | | 30. Name and address of person who cor | | , | , , , , , | | | | | | |
| | Sta | | Dr. Ronald E. Mi 31. Date filed (Month, Day, Year) | .11er 4 | | | or. Mt. | Airy M | ID 21771 | -531 | U | |
| | Pogistr | | FFR 2 1 2008 | | Ac | | e e | | | | | |

| | 1 - For State Registrar | | artment of Health and Me rtificate of Death | ntal Hygiene | 05170 |
|--|---|---|--|-------------------------------------|--|
| Physician | | si) | 2 | Date of Death Month Day Yeer | 3. Time of Death 8:30 Å M |
| /Medical Examiner | | e street and number) | 4b. City, Town, or Location of Death | 4c. County of Dea | ath |
| Funeral Director | 5. Social Security Number 6. S | | If Under 1 Year If Under 24 Hrs. 8 | (Month, Day, Year) C | nthplace (State or Foreign oursty) |
| D D | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Town or Lo | | 3-31-70 Mf | 10d. Inside City Limits |
| death with the Maryland ms 23e or 28e-1 show tribut be notified at | | RUNDE 282 500 | ITS CLEN CLEN | BLANIE | 1 ☐ Yes 2 【YNO |
| th with the with the with the major 238 or 2 | 10e. Street and Number 282 ScoTTS CLEN | | 10f. Zip Code 2 106 l | 10g. Citizen of What C | $5 \cdot A$. |
| Fig. 18 of Fig. 18 | 11. Marital Status 1 Never Married 2 Married | 1 ☐ Yes 2 ☑ No | Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2 ☑ No Specify: | | erican Indian, ite, etc. |
| 5-0036 2 hours after 2 hours after ical Examinated by Fun | 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E | Year or Dates: ducation 16a. Dece | dent's Usual Occupation | Specify 16b. Kind of Business | hit E s/Industry |
| PAA 121215-00 964 within 72 hou year. Per then "neture 1, the Medical E | (Specify only highest gra | College (1-4or 5+) | kind of work done during most of working DO NOT use retired) | ONLINE. | SALES |
| laryland 212 2 should be filed with and Mental Hygiene, and Mental Hygiene, and other the aumatic avent, the To Be Comi | 17. Father's Name (First, Middle, Last, | <u> </u> | 18. Mother's Name (F | First, Middle, Maiden Sumame) | |
| Aar | 19a. Informant's Name/Relationship (| Type, Print) 19b. Mailin | ng Address (Street and Number or Rural F | | Zip Code) |
| more, M Pages 1 and 2 pend of Health int: If item 27 inty or other tru | 20a. Method of Disposition 1 Burial 2 Ocremation 3 | 20b. Place of Dispo cemetery, cref | esition (Name of Date at a part of par | 20c. Location - City on | r Town, State |
| Baltimore, Benti, Pages 1 a Department of He, Important, If them any injury or othe | ' 4 □ Donation 5 □ Other (Specifical Signature of Fundamental Service Lice | ARDENT | CREMOTURY 2-12. Name and Address of Facility | -08 HANDVER | MD |
| W 88 5 8 8 | 23a. Part Enter the disease or com shock, or heart failure. List only | plications that saused the death. Do not ent | Daugherty Family Funeral Hom 2601 Mountain Road - I er the mode of dying, such as cardiac or n | Pasadena, MD. 21122 | Approximate Interval Between |
| Physician /Medical | shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) | a respiratory fail | luce | | Onset and Death |
| Examiner | | b. to que cance | | | 2 years |
| executed in and inal-transit | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a consequence of): | | | , |
| 18760, cate be executed physician and the burial-transit dical Examír | resulting in death) Last | Due to (or as a consequence of): | | | |
| Box 68 eath certifica attending ph for use as th | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pregnancy | | 23d. Date of de | alivery |
| P.O. Box 6 nat the death certific d by the attending 1 letached for use as | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | | Ectopic pregnancy Other (specify) | Month | Day Year |
| Vital Records, P.O. Box 6 sician: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as Be Completed by Physician/Mec | Part II. Other significant conditions of | contributing to death but not resulting in the u | nderlying cause given in Part I. | 23e. Did tobacco use contribute t | to the cause of death? |
| Division of Vital Records, or attanding Physician: The law requires that death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification; To Be Completed by | | | | 24a. Was an 24b. Were a prior to | utopsy findings available completion of cause of |
| /ital R clan: The entificate t sector, page | 25. Was case referred to medical | | 26. Place of Death (0 | performed? death? 1 Yes 2 No 1 Yes | s 2□No |
| of V 3 Physic ar this ce eral direc | examiner? 1 Yes 2 No 27. Manner of Death | Hospital: 1 Inpatient 2 ER/Outpatien 28a. Date of Injury (Month, Day Year) 28b. Time of Injury | | 5 Residence 6 Other (Spe. | ecify) |
| Division (tel or Attanding P rs after death. al Director: After ed in by the funer ed in by the funer | 1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined | | M 1 Tes 2 No | . Location (Street and Number or F | Rural Route Number, |
| Div pitel or / ours after eral Dire illed in b | 4 Homede | 28e. Place of Injury - At home, farm, str building, etc. (Specify) | , | City or Town, State) | |
| Division of Vital Records, P.O. Box 6 To the Hospitel or Attanding Physician: The law requires that the death certificate hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Medical Certification; To Be Completed by Physician/Mer | (Check only 2 Medical Exam | ysician: To the best of my knowledge, death niner: On the basis of examination and/or in and manner stated. | vestigation, in my opinion, death occurred | at the time, date and place, and du | e to the cause(s) |
| T with | 29b. Signature and title of certifier | CW- | 29c. License number 039639 | 29d. Date signed (Mon | |
| 10 | 30 Name and address of person who Ann Zimrin MD | completed cause of death (Item 23a) (Type, 22 S. Greene St | Baltimore ND | 21201 | |
| State Registrar | 31. Date filed (Month, Day, Year) FEB 2 1 2008 | 32. Registrar's Signature | K | | |

State Registrar

Irving Street N.W.Washington, D.C. PriebatM.D. 110 32. Segistrar's Signature 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
FFR 0 6 Dennis

DC10200

Feb. 5, 2008

20010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 2, 2008 **Physician** Helen A. Reger 6:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ginger Cove Health Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2XXF Hours Director 167-18-0004 87 12/27/1920 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? od other than "natural", or items 23a or event, the Medical Examiner must be i 4000 River Crescent Dr. 21401 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White 3 \ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be John Stank Anna unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David W. Reger/ Son 305 Hemstead Rd., Williamsburg, VA 23188 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery: 2/8/08 4 ☐ Donation Cheltenham, MD 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility George P. Kalas Funeral Home 2 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused line leath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** AtheroScle disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sician and burial-transit Due to (or as a consequence of): attending physician I for use as the buriz Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has i performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 415 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No Director 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760,

Certification: To 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 14300 Gallant Fox Ln., Rakesh Arora,

31. Date filed (Month, Day, Year)

FEB 0 5 2008

32. gistrar's Signature

Bowie, MD 20715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 05173

| Second Power Total Mind See Richardson See Richar | | | 1- For State Registrar | Cer | rtificate of | Death | | Re | eg. No. | |
|--|--|----------|---|--|-------------------|------------------------|------------------|---------------------|-----------------------|----------------------------|
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| Anne Aundel Medical Center 100 State 100 Cutty 10 | ral Exam | iner | Linda Lee Richards | on | | | | January 3 | 1, 2008 | 0719 hrs |
| Second Secondary Number Second Secondary Secondary | , | | | | | • | ocation of Death | | | |
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| Supplementary Supplementar | hour natu | ted | | | | | | | 16b. Kind of Business | s/industry |
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| Supplied | -00 d with giene ther t | mo; | | | 11011 | | 8.Mother's Name | e (First, Middle, I | | |
| Supplied | 215 e file tal Hy ked o | 3e C | Lawrence Fred | erick Banke | | | | | · | |
| Supplementary Supplementar | 21; ould b Men mark | | 19a. Informant's Name/Relationship (Type | , Print) | 19b. Mailing | Address (Street | | | | |
| Supplementary Supplementar | MD 2 shc h and 27 is | | Sharon A. Miller/ S | ister | 15030 | Clopper | Rd., Bo | oyds, MI | 20841 | |
| 29. Name and Address of Pacialty George P. Kalas Funeral Home 29.73 Solomons Island Rd. Edgewater. MD 2103 29. Name and Address of Pacialty George P. Kalas Funeral Home 29.73 Solomons Island Rd. Edgewater. MD 2103 29. Name and Address of Pacialty George P. Kalas Funeral Home 29.73 Solomons Island Rd. Edgewater. MD 2103 29. Name and Address of Pacialty George P. Kalas Funeral Home 29.73 Solomons Island Rd. Edgewater. MD 2103 20. Name and Address of Pacialty George P. Kalas Funeral Home 29.73 Solomons Island Rd. Edgewater. MD 2103 29. Name and Address of Pacialty George P. Kalas Funeral Home 29.73 Solomons Island Rd. Edgewater. MD 2103 29. Name and Address of Pacialty George P. Kalas Funeral Home 29. Name and Address of Pacialty George P. Kalas Funeral Home 29. Name and Address of Pacialty George P. Kalas Funeral Home 29. Name and Address of Pacialty George P. Kalas Funeral Home 29. Name and Address of Pacialty George P. Kalas Funeral Home 29. Name and Address of Pacialty George P. Kalas Funeral Home 29. Name and Address of Pacialty George P. Kalas Funeral Home 29. Name and Address of Pacialty George P. Kalas Funeral Home 29. Name and Address of Pacialty George P. Kalas Funeral Home 29. Name and Address of Pacialty George P. Kalas Funeral Home 29. Name and Address of Pacialty George P. Kalas Funeral Home 29. Name and Address of Pacial George P. Kalas Funeral Home 29. Name and Address of Pacial George P. Kalas Funeral Home 29. Name and Address of Pacial George P. Kalas Funeral Home 29. Name and Address of Pacial George P. Kalas Funeral Home 29. Name and Address of Pacial George P. Kalas Funeral Home 29. Name and Address of Pacial George P. Kalas Funeral Home 29. Name and Address of Pacial George P. Kalas Funeral Home 29. Name and Address of Pacial George P. Kalas Funeral Home 29. Name and Address of Pacial George P. Kalas Funeral Home 29. Name and Address of Pacial George P. Kalas Funeral Home 29. Name and Address of Pacial George P. Kalas Funeral | e, e, land I and Healt item | | | | | | etery, | Date | 20c. Location - City | or Town, State |
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| PitySician Edical Saminer 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of oying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of oying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of oying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of oying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of oying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of oying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 25a Part I. Enter the disease, or complications are considered to medical events resulting in death). Due to (or as a consequence of): 25a Due to (or as a conse | Iltin nit. P artme ortar ry or | | 21. Signature of Funeral Service Licensee | | | | | | Volos Euro | nol Uama |
| Physician actions are detailed. 20 | Ban Dep Dep Imp | | Illast Illas | | 20 | 73 Solom | one Tel | ond Rd | Edgovator | MD 21037 |
| Table 1. List only one cause on each line. Part List only one cause on each line. Dead | , Physician | | | | | | | | | Approximate Interval |
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| The control of the co | | | Sequentially list conditions. | | | | | | | |
| Very 1 to 1 t | | iner | | to (or as a consequence of | f): | | | | | |
| Open column Colum | | am | (Disease or injury that initiated C | to (or as a consequence o | f): | | | | | _ |
| Worth Day You was decedent pregnant in the past 12 months? Petul Day 10 | uted nd ransit | | | | , | | | | | |
| Worth Day You was decedent pregnant in the past 12 months? Petul Day 10 | exectan ar | ica | UNPENDED | MENDED | | | | | | |
| Past 12 months? Past 12 months? Past 12 mon | 60, ate be ohysic | Mec | IF FEMALE: 2 | 3c. If yes, outcome of preg | nancy | | | | 23d. Date of delive | ery |
| The state of the s | | | | | | tal death 3 | Ectopic pregn | ancy | Month | Day Year |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of de 1 Yes 2 No 3 Probably 4 Image: Property of the contribution of calculation of calculations and the contribution of calculations and the calculations and the contribution of calculations and the calculations and t | OX (ath ce attended or use | Si | 1 Nos 2 No 0 d Hatman | | eath 5 Ot | her (Specify) | | | 1 | |
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. Pebruary 1, 2008 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Signature | . B he de | hy | | | aculting in the I | indodvina cours si | won in Port I | 23e Did to | phacco use contribute | to the cause of death? |
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| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. Pebruary 1, 2008 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Signature | S, quires | fed | | | | | | | | |
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| State 31. Date filed (Month, Day, Year) 32. **Gistrar's Signature | Rec The l | Ę | | | | | | | 2 No 1 🗸 | Yes 2 No |
| State 31. Date filed (Month, Day, Year) 32. **Gistrar's Signature | al Fian: | | | | | 26.Place | of Death (Check | only one) | | |
| State 31. Date filed (Month, Day, Year) 32. **Gistrar's Signature | Vit hysic | | THOSE TOSE | ital: 1 Inpatient 2 | ER/Outpatient | 3 DOA | Other Nursi | ng Home 5 | Residence 6 Oth | ner: |
| State 31. Date filed (Month, Day, Year) 32. **Gistrar's Signature | n of ing P After unera | | 1 of Natural | 28a. Date of Injury (Month, Day, Year) | 28b. Time of I | | | 28d. Describe | how injury occurred | |
| State 31. Date filed (Month, Day, Year) 32. **Gistrar's Signature | ion trend Jeath. tor: | atio | J Pending | | | 1Y | es 2 No | | | |
| State 31. Date filed (Month, Day, Year) 32. **Gistrar's Signature | ViS or A of A Orice | <u>i</u> | 3 Suicide 6 Could not be | 28e. Place of Injury - At he | ome, farm, stre | et, factory, office bu | uilding, etc. | | | Rural Route Number, City |
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. Pebruary 1, 2008 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Signature | pital ours filled | Ser | 4 Homicide | (Specify) | | | | e) | | |
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| 296. Signature and title of certifier 296. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Signature 296. Date signed (Month, Day, Year) 296. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 | To th within To th | | and | the basis of examination a manner stated. | ind/or investiga | | | at the time, date | | |
| 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Signature | | Σ | 29b. Signature and title of certifier | 00 | | | | | | |
| Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31 Date filed (Month, Day, Year) 32. Signature | | | Carol HEl | llan | | O.C.N | /i. 上. | | rebruary 1, 20 | U8 |
| State 31. Date filed (Month, Day, Year) 32. Signature | ا ماد | | | | | | | | | |
| | 1913 | | · | | | Street, Baltimo | ore, MD 2120 | ון | | |
| Registrar FEB 0 5 2008 Elegan M. Apart a | | | | | | | | | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month OZ **Physician** Ricci 0524 A M Donald Robert 06 2008 /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salsani Manico Kegional Medical If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Days Hours †**⊈** M 2 □ F 61 Director 039-28-5319 4/24/ 1946 Rhode Island Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 1 √Yes 2 No Examiner must be notified Salisbury Director Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21804 1006 Beaglin Park Dr., Apt. 104 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ∏Yes 2 □ No If Yes, Give Year or Date AirForce 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: þ white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) USDA Food safety inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Anthony John William Ricci ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health as Important: If item 27 is any injury or other trav 8605 N. Prong Lane, Delmar, MD 21875 Diane K. Bradford/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ☐Donation 5☐Other (Specify) 2/7/08 Salisbury, MD Salisbury Crematory Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 0(Mangandy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cute disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner numonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Junknown 1 ☐ Yes 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed' death? 1 ☐ Yes 2∏ No 2 No

Hospital or Attending Physician: The law requires that the death certificate be executed and Box 68760, the Division or Vital Records, P.O. After ithin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu

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items 23a

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"natural",

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.

Completed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 No 2 ER/Outpatient 3 DOA 2 1 ☐ Yes 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

within 24 hours a To the Funeral C

30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print)

100E Carroll St. Salisbary r.R. M.C. MichaelBasae

31. Date filed (Month, Day, Year) 32. Registrar's Signature

FEB 0 8 2008

State

Registrar

29c. License number

29d. Date signed (Month, Day, Year)

| | 1 - For State Registrar | State of Maryla | | artment of H | | | jiene) (| 18 | 051 | 75 | | |
|--|---|---|---|---|---|---|------------------------------------|-----------------------------|---|---------------|--|--|
| | Decedent's Name (First, Middle, La | 2. Date of Dea | 2. Date of Death | | | 3. Time of Death | | | | | | |
| Physician /Medical | | y 12 20 | 80°C | 1105 | Ам | | | | | | | |
| Examiner | 4a. Facility Name (If not institution, gire | | | 4b. City, Town, or | Location of Dea | ath | 4c. County of Death | | | | | |
| | 148 Carters Mil | | | E1kton | | - 1 | Cec | | | | | |
| Funeral Director | | Sex 7. Age (In yrs | last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hr Hours Mir | | , Year) | _Count | ace (State or ry) aware | r Foreign | | |
| and | 10a. State 10b. County | 10c. C | ity, Town or Lo | cation | | | | 10 | d. Inside Cit | y Limits | | |
| Many Many Itor | Maryland Cecil | F | lkton | | | | | | 1 🗌 Yes | 2 ∑ No | | |
| deeth with the Maryland me 23a or 28e-f show rmust te mytified at | 10e. Street and Number | | | 10f. Zip Code | | 1 | log. Citizen of V | Vhat Counti | ry? | | | |
| 23a c | 48 Barksdale Co | urt | | 21921 | | | Unite | ed Sta | ates | | | |
| 5 4 B 5 | 11. Marital Status 1 Never Married 2 Married | If Yes, Give 10 | 54- 1 | Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🛣 No | spanic Origin? (n, Mexican, Pue Specify: | Specify Yes or No- erto Rican, etc.) | | e - America k, White, e | tc. | | | |
| Maryland 21215-0036 nd 2 should be filed within 72 hours at the and Mental Hygiene. 27 is marked other then "naturel", or retraumatic event, the Medical Event To Be Completed by F | 3 Widowed 4 Divorced | Teal of Dates. | | dent's Usual Occupa | ation | | 16b. Kind of Bu | Whit | | | | |
| on name of the part of the par | (Specify only highest gr | ade completed) | (Give | kind of work done of DO NOT use retired | turing most of w | orking | TOD. KING OF DO | 3111033711100 | ustry | | | |
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| tal Hy dother dother tal Hy | 17. Father's Name (First, Middle, Las |) | | | 18. Mother's N | ame (First, Middle, | Maiden Sumam | Θ) | | | | |
| Ment the Men | Harry J. Rhoade | s | | | Thel | na M. Ste | Stewart | | | | | |
| 2 sh 2 sh 1 s m 1 s m | 19a. Informant's Name/Relationship | ** | | | | Rural Route Number | | | Code) | | | |
| T, and tand the little of the rither the rit | Robert M. Rhoad | | | Carters M: sition (Name of | ill Road | l, Elkton | MD 219 | | - State | | | |
| nt of I | 1 ☐ Burial 2 X Cremation 3 [| Removal from State | cemetery, cren | natory or other plac | T CD | ruary | | | | | | |
| Description of the person of the mportent: If item in y injury or other ince. | 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice | | | s & Co., In | | 2008 | West (| Cheste | er, PA | | | |
| Depa Impo any in |) Sandy & | die a | Hi | cks Home | for Fur | erals P St., Elkt | A. MD | 21021 | | | | |
| Physician | 23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition | oplications that caused the dea one cause on each line. | | er the mode of dying | | | | 1 1 | Approximate Interval Betv Onset and D | veen | | |
| The law requires that the death certificate be executed the law requires that the death certificate be executed as the has been signed by the attending physicien end by age 2 should be detached for use as the burial-transit completed by Physician/Medical Examiner | resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Dute trudenty any that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | |
| , P.O. BOX 6i that the death certific led by the attending p detached for use as: | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No 9 Unknown | | 23d. Date of delivery Month Day Year | | | | | | | | | |
| Records, P. The taw requires that the tax section of the section o | Part II. Other significant conditions | 23e. Did tol | 23e. Did tobacco use contribute to the cause of death? 1 1 5 2 No 3 Probably 4 Unknown | | | | | | | | | |
| COrd w requir s been si s should leted | | | | | | 24a. Was a | n 24b. V | Vere autops | sy findings a | vailable | | |
| The law requir cate has been si page 2 should Completed | | | | | | autops perfori 1 Yes | med? p | rior to com | pletion of ca | use of | | |
| sicien: The sicien: The sicien: The sicertificate lirector, pag | examiner? | eath Check only on | th Check only one | | | | | | | | | |
| Physical Physics 12 CT | | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Residence 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred | | | | | | | Reside | ence- | | |
| th.: Afta | 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | fnjury | 28c. Injury Work | at ? ′es 2 □No | 200. Describe no | om admin occurr | 5 4 | | | | |
| To the Hospitel or Attending P within 24 hours eiter death. To the Funeral Director: Alfar I complately filled in by the funeral Medical Certification; | 3 Suicide 6 Could not be 4 Homicide determined | 00- 01 41 | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| he Hospitu in 24 hours he Funere plately fille edical C | | nysician: To the best of my kn niner: On the basis of examin and manner stated. | owledge, death ation and/or inv | occurred at the tim restigation, in my op | e, date and place sinion, death occ | ce, and due to the courred at the time, d | ause(s) and ma ate and place, a | nner as sta and due to t | ited. the cause(s) | | | |
| To th withir To th comp | 29b. Signature and title of certifier | | | 29c. License | number | 2 | 9d. Date signed | (Month, D | ay, Year) | | | |
| | Colonia | | mi | > Do | 056 | 149 | 2/1 | 2/0, | 8 | | | |
| 67 | ame and address of person who | completed cause of death (Ite | m 23a) (Type) | Printy LS | 1.5u, | Le 300 | 2 Elt | Stor | 1 M | 12/ | | |
| State Registrar | LLU 13 4 00: | 3ª: Registrar's Sign | ature | - AP | | | | | | | | |

WH-2

State Registrar Dr. Waseem

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

1126 Opal Court Hagerstown Maryland 21740

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** Month KATHERLNE 200 C /Medical 07 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs Months Days Hours Min. **Funeral** last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 □ M 2 🕶 F 93 521-46-1031 Director Sept. 1914 Hungary 3, Usual Residence of Decedent r 28a-f show notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be r 9320 Walden Rd. 20901 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2V No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Corset Makér Seamtress permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any light yor other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mor Ehrenfeld Anna Roth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Judy Stone/Daughter 1000 Miller Ave. Cumberland, MD 21502 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Lebanon Cemetery 2/4/2008 Adelphi, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral S 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW Washington, DC 20012

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 15 of the control of the contro Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Heart angestur /Medical Due to (overs a consequence of): Examiner Sequentially list conditions, if any list ling to import a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760 Physician/Medical as t attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. 2 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed Ronal Gusu 1□ Yes 2□No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No P 2 ER/Outpatient 3 DOA 1 ☑ Inpatient To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir this 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Solyusachi Var, M.D D0063703 02/02/ 2008 7600 CARROLL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NUENUE KAR SABYASACHI TAKOMA PARK MD 31. Date filed (Month, Day, Year) Rgistrar's Signature State FEB 0 6 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Feb. Physician 2008^{vear} 2, 1:50 PM Shipley Kathryn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sacred Heart Home Hyattsville Prince George's If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min. 1 ☐ M 2 💢 F 579**-**48**-**3671 102 Director 1905 Wisconsin Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d, Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2 📉 No Director Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 7107 Lory Lane 20706 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify Specify: White Completed by 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than amy injury or other traumatic event, the Monee. Statistician Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be St. Claire Pauquette Emma Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7107 Lory Lane, Lanham, MD 20706 Russell W. Shipley, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ammendale Normal Institute Feb. 8, 2008 Beltsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road, Beltsville Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 3 days Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause United that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed burial-trai Due to (or as a consequence of) P.O. Box 68760 Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕅 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Severe Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vinknown Completed page 2 should Failure to Thrive 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No autopsy certificate I 20 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 A Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the

> State Registrar

Medical

31. Date filed (Month, Day, Year) FEB 0 6 2008

howde

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29a. Certifier

(Check only one)



and manner stated.



1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D43121

29d. Date signed (Month, Day, Year)

February 4, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** 9 5:45 A February 2008 Betty Jane Sword /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Homewood Retirement Center Williamsport Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 ☑ F Feb. 25, 1931 Director 214-28-6016 76 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Washington <u>Hagerstown</u> 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 10911 Hopewell Road 21740 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2XXXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2\ No Specify 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Demit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other trainmant. 12 <u>Assembler</u> Glass Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shenebeck Samuel Elizabeth Chaney Mary 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10911 Hopewell Road Hagerstown, Maryland 21740 e of Disposition (Name of 2000) Date 200. Location - City or Town, State Charles Sword - Husband 20a. Method of Disposition
1 Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 3 ☐Removal from State 4 ☐ Donation 5 Other (Specify) Smithsburg Crematory | Feb.13,2008 | Smithsburg, Maryland 21. Signature of Funeral Service Lie Osborne Aderess of Facility Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MONX **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1☐ Yes 2 XNo Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **À** 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Yes 2 No death. 4 hours after death. 2 Accident filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

State Registrar of death (Item 23a) (Type, Print)

of person who completed cause

| | Dhysici | 20 | 1. Decedent's Name (First, Middle, Last) | | | | | | | | | 2. Date of Death Month 12 / 2 / 2 / 2 / 2 / 2 / 2 / 2 / 2 / 2 / | | | |
|--|--|----------------------------|---|---|--|----------------|--|--|-----------------|--|--------------------------------------|---|---|--|--|
| | Physici: /Medic | | Edith June Sams | | | | | | | | 2/3 | 3/2008 | roar | 2:34pm ^M | |
| | Examin | er | 4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center | | | | | 4b. City, Town, Annap | | of Death | | 4c. County of De | | | |
| ß, | Funeral Director | | 5. Social Security N 273–34–06 | 36 | Sex 7. 1 □ M 2 1 F | | 8 Yrs. | Months Days | | 24 Hrs. Min. | 8. Date of Birth | r ₉ 39 | 9. Birth | place (State or Foreign | |
| ore, Mar estand2sh | and w | ctor | Usual Residence of 10a. State | Decedent 10b. County | · | 10c. C | ity, Town or L | ocation | | | | | | 10d. Inside City Limits | |
| | e Maryla 3a-f sho tifled at | | | | | | Annap | | | | | | 1 □ Yes 2X No | | |
| | vith th | Director | 10e. Street and Number | | | | | 10f. Zip Code | | | | 10g. Citizen of | Og. Citizen of What Country? | | |
| | eath v Is 23a must | To Be Completed by Funeral | 29 Oak Ct. 11. Marital Status 12. Was Decedent Ever in U.S. 13. | | | | Was December of Hispania Origin 2 (Specify Vec or No | | | | USA 14. Race - American Indian, | | | | |
| | urs after d al'; or Item Examiner | | Armed Forces? 1 Never Married XX Married 1 Yes XX No If Yes, Give Year or Dates: | | | 7.0. | 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XNo Specify: | | | | Black, White, etc. Specify: White | | | | |
| | in 72 ho n "natur fedical I | | (Specify only highest grade completed) (Gi | | | | | edent's Usual Occu e kind of work done DO NOT use retire | st of work | ing | 16b. Kind of Business/Industry | | | | |
| | d with giene. rr thar | | Elementary/Secondary (0-12) College (1-4or 5+) | | | Ac | ctivities Director | | | | Nursing Homes | | | | |
| | buld be filed Mental Hyg arked othe atlc event, | | 17. Father's Name (First, Middle, Last) James Edward Gallaway | | | | 18. Mother's Name (First, Middle, Maiden Surname, Bertha Back | | | | | ame) |) | | |
| | 2 short and is m | | 19a. Informant's Name/Relationship (Type. Print) James Sams Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 Oak Ct. Annapolis, MD 21401 | | | | | | | | | ip Code) | | | |
| | Pages 1 ament of He ant: If Item ury or oth | | 1 Di Buriai 2 ICremation 3 Themoval from State | | | | cemetery, cre cemont | Memorial 2/7/2008 | | | | 20c. Location - City or Town, State Davidsonville, MD | | | |
| Dall | permit. Page Department of Important: If any Injury or once. | | 21. Signature of Fu | neral Service Lice | ensee | | 2 | 22. Name and Add | | | | | | e, P.A. | |
| Ä | 74.50 | | 23a. Part1. Enter the shock, or hea | ne disease, or con | mplications that cau y one cause on eac | sed the dea | th. Do not er | | | | | | | Approximate Interval Between | |
| | Physician /Medical | | Immediate Cause (disease or condition resulting in death) | Final | _a W | as a conse | M | C B | NOS | 5 | CAW | ZER | | Onset and Death | |
| 2 3 | Examiner | Physician/Medical Examiner | Sequentially list con | theriste III | b. Due to (or | as a conse | quence of). | | | | | | | | |
| | executed in and ial-transi | | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C | | | | | | | | | | | | |
| 08/00, | ficate be physicia s the bu | | | | d | | | | | | | | | · | |
| hat the death cert by the attending detached for use | the death certil the attending ched for use a | | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown | | | | | | | y 23d. Date of delivery Month Day Year | | | | | |
| | s that t ned by e detac | by Ph | Takin out of significant contained contributing to death but not resoluting in the alternying dade given in Fact. | | | | | | | | obacco use co | acco use contribute to the cause of death? | | | |
| ecords, | equire sen sig ould b | | INTEST MAR BLOODING | | | | | | | 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown | | | | | |
| | The ate har page | Be Completed | | | | | | | <u> </u> | | 24a. Was autor perfo 1∐ Yes | | o. Were au prior to c death? 1 🗆 Yes | topsy findings available completion of cause of 2 No | |
| VII | Physiclan: r this certific ral director, | | 25. Was case refer examiner? | | Hospital: | | | | thor: | | h (Check only o | | - | | |
| 0 | y Physer this eral di | . To | Inparient 2 E-routipatient 5 DoA 4 Nursing Home 5 Hesidence 6 Dother (Specify) | | | | | | | | cify) | | | | |
| 0 | ath. or: Afte | ation | 1 Natural 2 Accident | 5 ☐ Pending investigation 6 ☐ Could not | on | Day Year) | Injury | | ork? ⊒Yes 2□ |]No | | | | | |
| DIVISION | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. | Certification: | 3 ☐ Suicide 4 ☐ Homicide | treet, factory, office | City or Town, State) | | | | | ral Route Number, | | | | | |
| | e Hospi 124 hou e Funer letely fill | edical (| 29a. Certifier (Check only one) 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. | | | | | | | | | | | | |
| l | To th withir To th comp | Me | 29b. Signature and the of certifier 29d. Pate signed (Month, Day, Year) | | | | | | | | | | | | |
| 4 | 15 | | 30. Name and add | est of person who | o completed cause | death (Ite | 3(Type | , Print) | G SA | 2 | CIN | 2140 | \ | | |
| ľ | Sta Registi | | 31. Date filed (Mon | | 2008 32. | jistrar's Sigr | nature | porte | | | V | | , | | |
| Du | | 001 | | | | | - | | | | | | | | |

| 1 | For State Registra |
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| 1 | . Decedent |

State of Maryland / Department of Health and Mental Hygiene

05121

| | | | Registrar | | | C | ertificate of | 1 | Reg. No. 4 UUO UJ | | | | | |
|---|---|--|---|----------------------|------------------------|----------------------------------|---|-----------------|-------------------|----------------------------|--------------------|------------------------------|--|--|
| | | | 1. Decedent's Name (First, Middl | le, Last) | | | | | | 2. Date of De | | | 3. Time of Death | |
| | Physicia /Medic | | Peggy King St | taake | | | | | | Month Februa | ary 5 | , 2008 | 6:35 A M | |
| | Examin | Santia | 4a. Facility Name (If not institution | | umber) | | 4b. City, Town, | or Location | n of Death | | | County of Deal | th | |
| | | | 2701 Martello I | Drive | | | Silver S | Spring | 2 | | Mo | ntgomer | v | |
| | Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In | yrs. last birthda |) If Under 1 Year | r If Unde | er 24 Hrs. | 8. Date of Bi (Month, D | | 9. Birl | hplace (State or Foreign | |
| | Director | | 372-20-7856 | 1 □ M 2 🛣 F | | 83 Yrs. | Months Days | Hours | Min. | May 18 | ay, Year) 3, 19 | 24 Mic | chigan | |
| in . | - 10- | } | Usual Residence of Decedent | | 1 | - 0 3 | | | 2 1 11110 | | | | | |
| /Janc | Mo to | | 10a. State 10b. County | 1 | 100 | :. City, Town or I | ocation | | | | | | 10d. Inside City Limits | |
| Man | f sh | ō | MD Montgo | 0m0237 | c ÷ | lver Sp | rina | | | | | 1 □ Yes 2 🛣 No | | |
| the the | 28a notii | Director | 10e. Street and Number | Jine Ly | | TAGE DD | 10f. Zip Code | | | | 10g. Citiz | 0g. Citizen of What Country? | | |
| with | a or | | 2701 Martello I | Orino | | | 20904 | | | | | USA | | |
| eath | nus | Funeral | | | cedent Ever | in IIS 119 | | Hienanie C | Origin? (Sno | oify Voc or N | | | | |
| er d | Item | Ë | 11. Marital Status1 Never Married 2 Mar | Armed F | orces? | 11 0.5. | . Was Decedent of If Yes, specify Cu | ban, Mexic | an, Puerto | Rican, etc.) | , | Black, White, etc. | | |
| saft | , or | by F | 3 ☑ Widowed 4 ☐ Divorced | If Yes. G | 2 X No aive | | 1 ☐ Yes 2 💢 No | Specif | jy: | | | Specify: Whi | +0 | |
| Pour | tural al E | | | nt's Education | Duics. | 16a Dec | edent's Usual Occi | ınation | | | | nd of Business | | |
| n 72 | "na edic | Completed | (Specify only highe | est grade completed |) | (Giv | re kind of work done DO NOT use retir | e during mo | ost of worki | ing | TOD. KI | ild of busiless | industry | |
| with 1 | than than | Ē | Elementary/Secondary (0-12) | College 4 | (1-4or 5+) | | maker | , | | | Orm | Home | | |
| iled | Hygi Ither Int, It | | 17. Father's Name (First, Middle, | <u> </u> | | поше | maker | 18 Mot | her's Name | (First, Middle | 1 | | | |
| be | d of | Be | | | | | | | | | , maiden | ourname) | | |
| Plno | Mer | 유 | William McKinle | | | | Nellie May Harb 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code | | | | | | | |
| 2 sh | ls m | | 19a. Informant's Name/Relations | | | | | | | | | | | |
| and | n 27 n 27 ier tr | | David Staake/so | <u> </u> | | | Jacobs N | | w DIT | ve seve | ST II | FID 2112 | +4 | |
| es 1 | of H filter | | 20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation | 3 D Romoval from | n State | Ob. Place of Dis cemetery, ci | oosition (Name of ematory or other pl | ace) | | Date | 20c. Lo | cation - City or | Town, State | |
| Pag | nent int: I | | 4 □ Donation 5 □ Other (5 | Specify) | C | Chesapea | ke Cremat | tory | 02/0 | 7/08 | Be1t | sville, | MD | |
| Ë | Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 21. Signature of Funeral Service | Licensee | 211 | 0 | 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 | | | | | | 78/ı | |
| <u>a</u> | Depa Impo any ir once. | | Alexander | 2 L Her | the | | | | | | | | e, MD 21029 | |
| - | | | 23a. Part1. Enter the disease, o shock, or heart failure. List | r complications that | caused the | death. Do not e | nter the mode of dy | ing, such a | as cardiac c | or respiratory | arrest, | IKSVIII | Approximate Interval Between | |
| E DIE | | | Immediate Cause (Final | | | * | | | | | | | Onset and Death | |
| | ysician Medical | | disease or condition resulting in death) | | NGES | | CARDIO | MYOI | 7H1H | 4 | | | | |
| | caminer | | | _ | | nsequence of): | | | | | | | | |
| | | - | Sequentially list conditions, | D | | nsequence of): | INIA | | | | | | | |
| pet | ısit | i | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | | | | |
| Kecur | sician and burial-transit | Examiner | that initiated events resulting in death) Last | c | o (or as a cor | nsequence of): | | | | | | | | |
| be e | cian | | | | (| | of): | | | | | | | |
| certificate be executed | ending physic use as the b | n/Medical | | d | | | | | | | | | | |
| ertifi | ding e as | Me | IF FEMALE: | 200 15 | | | | | | | | | | |
| | attend for us | an/ | 23b. Was decedent pregnant in the past 12 months? | | birth 2 🗌 | Fetal death 3 | □Ectopic pregnan | су | | | 1 2 | 23d. Date of de Month | livery Day Year | |
| e de | the a | sic | 1 Yes 2 No 9 Unknown | 4∐Preg 9□Unk | gnant at time :nown | of death 5 | Other (specify) | | | | | | Duy Four | |
| at th | by the stached | Physicia | | | | | | | | | | | | |
| es t | gned be d | þ | Part II. Other significant conditi | ions contributing to | death but no | t resulting in the | underlying cause g | liven in Par | t I. | | \ | | o the cause of death? | |
| equir | s been sign e d t should be det | ed | | | | | | | | 1 _ | Yes 2 | 2 (100 3 □ P | robably 4 □Unknown | |
| aw | s be 2 sh | Completed | | | | | | | | 24a. Wa | | 24b. Were a | utopsy findings available completion of cause of | |
| The | age | E O | | | | | | | | per | opsy ormed? | death? | | |
| E | tifica or, p | | 25. Was case referred to medica | al | | | | 26 Pla | ice of Death | 1□ Yes h (Check only | 2 100 | 1 ☐ Yes | 3 2 □ No | |
| sicl | r this certificate has tral director, page 2 s | o Be | examiner? 1 ☐ Yes ≥ No | Hospital: | Inpatient | 2 ER/Outpati | ent 3 DOA | thor: | | me 5□Res | | c Nother /Con | GRUP Boilty) HOME | |
| F. | ar this | ٠. T | 27. Manner of Death | 28a. Date | e of Injury | 28b. Time | of 28c. Inj | | | 28d. Describe | | | HOINE | |
| ding | h. Affe fune | tior | 1 Natural 5 ☐ Pendii 2 ☐ Accident investi | ng (Mo tigation | onth, Day Ye | a <i>r</i>) Injun | | ork? ⊒Yes 2[| | | | | | |
| Atte | deat ctor y the | lica | 3 Suicide 6 Could | not be 28e. Plac | ce of injury - | At home, farm, | street, factory, office | Ð | | 28f. Location | (Street an | nd Number or B | ural Route Number, | |
| <u> </u> | after Dire I in b | Certification: | 4 ☐ Homicide determ | buil | lding, etc. (S | pecify) | • | | | City or To | wn, State |) | | |
| pita | ours reral fillec | 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one) September 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) | | | | | | | | | s stated | | | |
| Hos | 24 h 9 Fur etely | | | | | | | | | | e to the cause(s) | | | |
| of the Hospital or Attending Physician: The law requires that the death | within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | A | | | | | | | | th, Day, Year) | | | | |
| - | × ⊢ 0 | | Almoral | man | i M | · D . | D- | 276 | 60 | | 21 | 6108 | | |
| 1 | 106 | | OO Nome and of the of | nuba nameleted | | (Ikam OC-) /T | | | | | ~1 | -1-0 | | |
| 2 | EG. | | 30. Name and address of person | AMI, M.S. | use or death | (item 23a) (Typ | e, Print) | (e. S. | its | 110 R | cK. 11 | 15 mh | 20857 | |
| - | C+o | to | 31. Date filed (Month, Day, Year | | Registrar's | | VIIIE III | | 110 | -7- 3-3 | 1011 | -1.10 | 00000 | |
| | Sta Registr | | made attraction of the | 7 2008 | March. | . 1 | South 1 | | | | | | | |

Physician Smith Harriett Jeanne FEBRUARY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HAMAUN REGIONAL SALVEHUL If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🔀 F 218-16-5746 82 2/2/1926 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director Worcester Ocean City Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21842 9307 Chesapeake Dr., Unit 37 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify 2 3 ₩ Widowed 4 Divorced SWITH Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental I Be Elva R. Ruark Oscar H. Adkins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra once. 30215 Stoneybrooke Dr., Salisbury, MD 21804 William T. Smith III/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages ' 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 2/8/2008 Parsons Cemetery avia Ato V 21/Signal 22. Name and Address of Facility Holloway Funeral Home Professional Association 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Immediate Cause (Final disease or condition resulting in death) **Physician** ENGOLATED MIESTINE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate caus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the

1. Decedent's Name (First, Middle, Last)

23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 1 No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed: 2A No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) inpatient 1 Tyes 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred Naturai 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tile of ce

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.-

2008

NICHMICO

14. Race - American Indian,

white

Black, White, etc.

real estate

Salisbury, MD

02

94

50

4c. County of Death

USA

2. Date of Death

3. Time of Death

1820

10d, inside City Limits

Approximate Interval Between Onset and Death

1 XYes 2 No

Birthplace (State or Foreign Country)

Maryland

after death.

Director: /

24 hours a e Funerai I

To the Hosp within 24 hor To the Functional

Division or Vital Records,

Hospital or Attending Physician:

DHMH 17 Rev 1/2001

attending pl for use as t

page 2 s

2

Be Completed

Certification: To

Medical

30. Name and address of

31. Date filed (Month, Day

FEB 08

Vear)

State Registrar Registrar's Signature

100 E. CAMON

pleted cause of death (Item 23a) (Type, Print)

ST. SAUSBUM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** LUCILLE J. SHERIFF FEB 2008 5:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner COPPER RIDGE SYKESVILLE CARROLL 5. Social Security Number If Under 1 Year Months | Days 8. Date of Birth

JULY 22 2 1 916 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex Funeral Hours 1 ☐ M 2 🕱 F 577-05-0818 91 Director ΜD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ? Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at ADAMSTOWN FREDERICK 1 ☐ Yes 2 No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21710 USA 5817 UNDERWOOD CT. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE Specify: Specify þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within ealth and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PEPCO SECRETARY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MAMIE PYLES JOHN AUGUSTUS JONES ္ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other tra CHARLES ELGIN, JR./NEPHEW 5817 UNDERWOOD CT., ADAMSTOWN, MD 21710 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/8/2008FREDERICK, MD STAUFFER CREMATORY 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HILTON FUNERAL P.O. BOX 86, BARNESVILLE, MD 23a. P. 111. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHEROSCLEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the nast 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

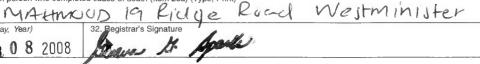
1 ☐ Yes 2 ☐ No 24a Was an Was an autopsy performed?
Yes 2 No te 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 N Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No. 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: ↑ Natura! 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Registrar

DHMH 17 Rev 1/2001

To the Funeral

31. Date filed (Month, Day, Year) FFR 0 8 2008



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29a Certifier

La Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D43725

29d. Date signed (Month, Day, Year) 218/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Feb. 3:30 Pm **Physician** Geraldine Mildred Spicer 12 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Parkton 18233 York Road 8. Date of Birth (Month, Day, Year) OCT. 24, 1927 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Mary land 1□M 2XF Yrs. 80 220-22-4181 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Show rthan "natural", or items 23a or 28a-f shov the Modical Exeminer must be notified at 1 ☐ Yes 2X No Parkton Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21120 18233 York Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No 72 hours after 1 Never Married 2 Married White Specify: 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 q 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Postal Clerk is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 should be f and Mental h Mildred Wilhelm Charles Reidt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) itam 27 is 18233 York Rd., Parkton, MD 21120 Kenneth M. Spicer 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Feb. ō 1 Burial 2 □ Cremation 3 □ Removal from State White Hall, MD Department of Important: If any injury or once. Wiseburg Cemetery 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 21. Signature of Funeral Service Licens 24 Second St., New Freedom, PA 17349 artens awes. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mulle Physician me /Medical Due k (or as a consuluence of): Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FFMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 poinths? 3 Ectopic pregnancy Year 4 Pregnant at time of death 5 Dther (specify) P.0. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ð 1 ☐ Yes À ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b irector, page 2 sl performed 1 ☐ Yes 1 Tes 2 🔯 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 200 No 5 A sidence 6 □Other (Specify) ဥ this 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 27. Manger of Death Certification: Hospital or Attanding 1 Netural 2 Accident 5 Pending investigation 2 🗆 No 1 TYes efter death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 🗌 Suicide determined filled in by 4 \ Homicide 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2. tha 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of confilier

Registrar

State

7

30. Name and address of

31. Date filed (Month, Day, Year)

32. Registrar's Signature

(Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Valene В. Tolman 2008 February :24 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Center Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 520-14-7227 Director 88 October 11, 1919 Wyoming Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🙀 No Director MD Charles Waldorf 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 Wicklow Court 20602 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White <u>ک</u> 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Loraine Brown Mable Wilkes ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Waite/Daughter 5 Wicklow Court, Waldorf, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Logan City Cemetery 2/11/2008 4 ☐ Donation 5 ☐ Other (Specify) Logan, Utah 21. Signature of Funeral Service Licensee 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, P.A. M00945 a 211 St. Mary's Ave. La Plata, MD 20646 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Conjestive heart failu.
Due to has a consequence of): **Physician** Unknow /Medical Examiner unknow. Cercho vasula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician the as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ XNo Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 8 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? 1☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 🔀 Inpatient 2 ER/Outpatient 3 🗆 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 M Natural 1 ☐ Yes 2 ☐ No investigation 24 hours after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M. 0 2.5.08 043446 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

ROINTAN FARAHIFAR

FEB 07

2008

31. Date filed (Month, Day, Year)

32. gistrar's Signature

9801 Georgia Aresuit 3-41 Silver Spring MD 20902

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jason Taylor Jamaal 2045 PM 02 02 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** REGIONAL NICONION SAUSBURY Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Months Days 1**X**M 2□F Min. n/a Feburary 2,2008 MARYLAND Director Usual Residence of Decedent 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturat"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 XYes 2 No Director Crisfield Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21817 279 Somers Cove Apartments USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: ģ Specify: BIACK 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a n/a 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ ranci Kenee 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 279 Somers Cove Apts., Crisfield MD 21817 Alison R. Jones/mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 2/5/08 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service Licery ee 22. Name and Address of Facility Holloway Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** xtreme disease or condition resulting in death) /Medical Due to for as a consequence of Examiner reterm Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the deeth certificate be executed ohysician and the burial-trans Due to (or as a consequence of) Box 68760 physician Physician/Medical SS attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 page 1□ Yes 2 100 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: ၉ 1 Dipatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

Lu

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State Registrar 3C Date filed (Month, Day, Year) FEB 0 8 2008

EISEMANN

30. Name and agaress of person

32 Registrar's Signature

100 E. OAKKOIL

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per / th 877 3-24-08 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 07:58 AM LEM TAYLOR 02 2008 09 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner V.A. MEDICAL CENTER NIA BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 6/8/1936 Months 1**X**□M 2□F Davs Hours VIRGINIA 225-46-5075 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show WV BERKELEY MARTINSBURG ns 23a or 28a-f sh πust be notified 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 510 BUTLER AVENUE 25405 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mential Hygiene. Important: If Item 27 Is marked other than "natural", or iten any Injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ (No Specify: þ BLACK 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US NAVY SEAMAN UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname)
EVA DOWDY 17. Father's Name (First, Middle, Last) Be JUNE TAYLOR ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or TMD, State, Zip Code) 1314 PALMER RD., FORT WASHINGTON, PA 20744 19a. Informant's Name/Relationship (Type. Print) STEPHANIE ANDERSON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State FEBRUARY 1 X Burial 2 Cremation 3 Removal from State MT. HOPE CEMETERY MARTINSBURG, WV 4 ☐ Donation 5 ☐ Other (Specify) 15, 2008 22. Name and Address of Facility 21. Signature of Funeral Service Licensee BROWN FUNERAL HOME, P.O. BOX 821, 327 W. KING ST.<u>, MARTINSBURG, WV 25402</u> 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PANCREATITIS GALLSTONE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and Due to (or as a consequence of): Box 68750, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ၉ 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: the Hospital or Attending 5 Pending investigation 1 Natural Injury within 24 hours after deam.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number NPI# 02-09-2008 CHIEMAR, MD (RESIDENT) 1992913735

Registrar

31. Date filed (Month, Day, Year)

TIMETHY P. CHIZMUTE,

mD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature The same

22 SOUTH GREENE ST. BALTIMIRE, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3,700,8 **Physician** David Welsie Tyler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbur Wicomi Hospice at the castal If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F 05/08/1936 **Director** 216-34-8604 Marvland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Dorchester Fishing Creek 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 2137 Hoopersville Road 21634 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Waterman Seafood 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Oliver George Tyler Ella Marie Rhea 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 2137 Hoopersville Rd. Fishing Creek, MD 21634 Cloria Leila Tyler/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If It any Injury or o once. 1 ☐ Burial 2 K☐ Cremation 3 ☐ Removal from State MidShoreCremationCenter 2/14/2008 Cambridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Id Shore Cremation .0. Box 1464, 2272 nature of Funeral Eervice Licensee Center Hudson Rd. Cambridge, MD 21613 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Carcles Physician Tastat/L disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ၉ this within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27 Manner of Death 28a Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident (Month, Day 5 Pending investigation 1 Yes 2 No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Doud E Court MD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

82. Registra

| | | For State Registrar | | State of | f Marylan | | artment of ctificate o | | | ental Hy | /giene Reg. No. | 2008 | 05189 |
|---|----------------|--|---|---------------------------|--|----------------------------------|---|----------------------------------|---------------------------|---------------------------------------|---------------------------|--|--|
| Physici /Medic | | Decedent's Nam Ross | e (First, Middle, La Lynn | | rplank | | | | | 2. Date of De Month Febru | Day | Year 5, 200 8 | 3. Time of Death 1:14 PM |
| Examir | | 4a. Facility Name (/ | If not institution, giv | | nber) | | 4b. City, Town | | of Death | | 4c. (| County of Dea | th |
| Funeral Director | | 5. Social Security N 368-34-1 | | Sex 1.121 M 2.□F | 7. Age (<i>In yrs.</i> | last birthday) Yrs. | If Under 1 Yea Months Day | | 24 Hrs. Min. | 8. Date of Bi (Month, D. 4/17/] | ay, Year) | Co | thplace (State or Foreign buntry) LChiqan |
| yland how at | | Usual Residence of 10a. State | f Decedent 10b, County | | 10c. Cit | y, Town or Lo | cation | | | | | | 10d. Inside City Limits |
| the Ma 28a-f s ottfled | Director | Maryland 10e. Street and Nu | Wicom | ico | 5 | Salisbu | 10f. Zip Code | | | | 10a Ciri | zen of What Co | 1 My Yes 2 No |
| h with 1 23a or 3 st be n | al Dir | 111 - 111 | verside l | Orive | | | 218 | | | | rog. Citiz | USA | ounity? |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral | 11. Marital Status 1 □ Never Marr 3 □ Widowed | ried 2⊠ Married 4 □ Divorced | Armed Fo | 2 □ No | | Was Decedent of Yes, specify C | uban, Mexica | ın, Puerto I | cify Yes or No Rican, etc.) | | I4. Race - Ame Black, White Specify: | |
| /ithin 72 ho ne. han "natu e Medical | Be Completed | Elementary/Seco | 15. Decedent's E cify only highest gr ondary (0-12) | ade completed) College (1 | -4or 5+) | (Give life. i | dent's Usual Occ kind of work dor DO NOT use reti | ne during mos red) | | ng | | nd of Business | /Industry |
| filed w Hygiel Other ti ent, th | | 12 17. Father's Name | (First, Middle, Las | <u>4+</u> | | respi | ratory_ | | | (First, Middle | <u> </u> | pital Surname) | |
| ould be Mental arked atic ev | To B | | Dewey Vo | | · | | | | | s Isabe | | | |
| and 2 sh ealth and n 27 is m er traum | | Elizabet | ame/Relationship | | | 723 | ng Address (Stre Riversi | | , Sai | lisbury | y, MD | 21801 | |
| Pages 1 ment of H ant: If iter lury or oth | | | Cremation 3 | | State | cemetery, crei | sition (Name of matory or other p Cremat | , i | |)8 | | isbury | |
| permit. Depart Import any inj | | 2) Signature of Fu | Salisbury Crematory 2/7/08 Salisbury, MD | | | | | | | | | | |
| Physician /Medical | | 23a, Part1, Enter t | on | one cause on e | aused the deat ach line. | h. Do not ent | er the mode of c | | 1 | r respiratory | | 2 | Approximate Interval Between Onset and Death |
| Examiner | Examiner | Sequentially list co | onditions, | b | or as a conseq | | | Ä. | | | | | |
| ficate be executed physician and s the burial-transit | | Sequentially list contains, reading to it cause. Enter Under Cause (Disease or that initiated events resulting in death) | erlying r injury s Last | c | or as a conseq | uence of): | | | | | | | |
| icate be executed physician and s the burial-transit | dical | | (| d | | | | | | | | | |
| The law requires that the death certifiate has been signed by the attending age 2 should be detached for use as | Physician/Me | IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 I 9 ☐ Unknown | 2 months? | 1 ☐ Live b | come pf pregna pirth 2 Feta nant at time of co | al death 3 | ⊒Ectopic pregna ∃Other (specify) | | | | 2 | 23d. Date of de Month | elivery Day Year |
| quires that in signed build be deta | by | Part II. Other signi | ificant conditions | contributing to de | eath but not res | ulting in the u | nderlying cause | given in Part | 1. | | tobacco u] Yes 2[| | to the cause of death? Probably 4 ☑Unknown |
| The law requii ate has been s page 2 should | Completed | | | | | | | | | 24a. Wa: auto peri 1 Yes | opsy formed? | 24b. Were a prior to death? | |
| is certificate director, pag | Be | 25. Was case reference examiner? | | Hospital: | | | [6 | Other: | | (Check only | | | |
| ding Ph After th funeral | ation: To | 1 ☐ Yes 2 ☑ 27. Manner of Dea 1 ☑ Natural 2 ☐ Accident | | 28a. Date (Mon | | 28b. Time o Injury | f 28c. Ir | ijury at /ork? □ Yes 2 □ | 1 | me 5 ⊋ Res 28d. Describe | | Other (Sp. y occurred | ecify) |
| tal or Atters after der al Directo | Certification: | 3 ☐ Suicide 4 ☐ Homicide | 6 Could not be determined | 20e. Place | of injury - At heng, etc. (Speci | ome, farm, str fy) | eet, factory, office | ce | 1 | | (Street and own, State | | Rural Route Number, |
| To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the | edical | 29a. Certifier (Check only one) | 1 Certifying P 2 Medical Exa | miner: On the b | e best of my kno asis of examina ner stated. | owledge, deat ation and/or in | h occurred at the vestigation, in m | e time, date a ly opinion, de | and place, eath occurr | and due to the | e cause(s) e, date and | and manner a I place, and du | as stated. ue to the cause(s) |
| E # E # | M | 29b. Signature and | d title of certifier | ykr | | | _ | 292 | 28 | 3 | 29d. Dat | e signed (Mor | nth, Day, Year) - 200] |
| 1 gu | | 30. Name and add | ress of person who Taylor | | | | Print) Salisb | ury, M | ID 218 | 301 | | | |
| Sta Regist | | 31. Date filed (Mor | nth, Day, Year) EB 0 8 20 | | tegistrar's Signa | | | | | | | | |
| negisi | 150 | , | 0 0 20 | Ties. | Car X | r Age | 3.30 | | | | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death **Physician** February 3, A M 9:15 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2/XF 212-03-5073 Director 90 July 15, 1917 Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits fshow r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√No Directo Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Bestgate Road Apt 219 21401 United States by Funeral filed within 72 hours after death 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes ★ No If Yes, Give X Year or Dates: 3altimore, Maryland 21215-0036 1 ☐ Yes XX No Specify Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event once. Be (Ernest Conrad Wimmer Marion Crouch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynn T. Ridgely / Daughter 205 East Joppa Road Apt 1106 Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Baltimore Crematory 2/5/2008 Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licens John M. Taylor Funeral Home, 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to deat _but not resulting in the underlying cause given in Part I 23e. Did tobacco wse contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∏ Yes the Hospital or Attending Physician; hin 24 hours after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 5 Residence 6 Other (Specify) 1 | Yes 2 | No. 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Descritiving Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Year) FEB 0 5 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | 1 - State Registrar | | C | ertificate of | Death | Re | _{eg. No.} 2008 | 05191 |
|---|------------------|---|--|-------------------------------------|--|-------------------------------------|--|---|--|
| | | 1. Decedent's Name (First, Middle, La | st) | | | | 2. Date of Deat Month | h Day Year | 3. Time of Death |
| Physicia /Medic | | Lewis Jerome Wa | then | | | | February | 1, 2008 | 5:30PM M |
| Examin | | 4a. Facility Name (If not institution, give | e street and number) | | 4b. City, Town, o | or Location of Deat | h | 4c. County of Death | |
| | | 9780 Royal Oak Dri | | | La Plat | | | Charles | |
| Funeral | | Social Security Number 6. S | ex 7. Age (In yrs | . last birthd Yrs | Months Days | If Under 24 Hrs Hours Min. | 8. Date of Birth (Month, Day, | Year) 9. Birth | place (State or Foreign intry) |
| Director | | 578-56-5664 | 65 | TIS | 5. | | May 17, | 1942 Mar | yland |
| and w | | Usual Residence of Decedent 10a. State 10b. County | 10c. C | ity, Town o | r Location | | | | 10d. Inside City Limits |
| Maryl f sho ed al | ō | 1 1 01 1 | | | | | | | 1 ☐ Yes 2 ☐ No |
| the 1 28a- notiff | rect | Maryland Charles 10e. Street and Number | | a Pla | 10f. Zip Code | | 1 | 0g. Citizen of What Cou | untry? |
| with 3a or t be | Funeral Director | 9780 Royal Oak Dr | ive | | 206 | 46 | | United Sta | tes |
| ns 2% | lera | 11. Marital Status | 12. Was Decedent Ever in | J.S. | 13. Was Decedent of I If Yes, specify Cub | | Specify Yes or No- | 14. Race - Amer | ican Indian, |
| r iter | Fur | 1 ☐ Never Married 2 ☑ Married | Armed Forces? 1 ☐ Yes 2 ☑ No | | | | to Rican, etc.) | Black, White | |
| al", o | by | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | | 1 □ Yes 2 및 No | Specify: | | Specify: Wh: | ite |
| 72 ho | Completed | 15. Decedent's Ed (Specify only highest gra | ducation | 16a. De | ecedent's Usual Occu- | pation | rking | 16b. Kind of Business/I | ndustry |
| thin an "le | nple. | Elementary/Secondary (0-12) | College (1-4or 5+) | - \in | live kind of work done fe. DO NOT use retire | ed) | g | | |
| ed wi | ဦ ပ | 12 | | Ass | <u>istant Man</u> | | | Food Ser | vices |
| be filed within 72 hours after death with the Maryland ital Hygiene. Ital Hygiene, ad other than "natural" or items 23a or 28a-f show event, the Medical Examiner must be notified at | Be | 17. Father's Name (First, Middle, Last, | | | | _ | me (First, Middle, I | Maiden Surname) | |
| Men arke | ပ္ | Joseph Edward Wat | | | | | Wathen | | |
| and and ls m | | 19a. Informant's Name/Relationship (| Type. Print) | 19b. M | lailing Address (Street | t and Number or R | ural Route Number | r, City or Town, State, Z | ip Code) |
| and lealth m 27 | | Ellen Wathen-Wife | look | | | | | Maryland 2 | |
| ges 1 f of H f ite | | 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ | Removal from State | cemetery, | isposition (Name of crematory or other pla | ace) | Date | 20c. Location - City or | rown, State |
| Pa tmen tant: jury | | 4 Donation 5 Other (Specif | y) Ne | wport | Cemetery | | | 8 Newport | |
| permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiens. Important: if item 27 is marked other than "n any injury or other traumatic event, the Medione. | | 21. Signature of Funeral Service Lice | see / / / M009 | 45 | | | | ols Funeral | |
| <u> </u> | | Davi. | E TWO | I | | | | a, Maryland | |
| | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | one cause on each line. | | | ing, such as cardia | c or respiratory arr | est, | Approximate Interval Between Onset and Death |
| Physician | | Immediate Cause (Final disease or condition resulting in death) | a Leur | en | nia | | | | |
| /Medical Examiner | | resulting in death) | Due to (or as a conse | equence of): | | | | | |
| | <u>.</u> | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (or as a conse | nuence of | | | | | |
| ted 1sit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | 200 10 (01 40 4 001100 | 400,000 01) | | | | | |
| xecu al-trai | xar | that initiated events resulting in death) Last | c Due to (or as a conse | quence of): | : | | | | |
| cate be executed physician and the burial-transit | | | u. | | | | | | |
| icate phys | Medical | | Q | | | | | | |
| n certifica anding pl use as t | _ | IF FEMALE: 23b. Was decedent pregnant | 23c. if yes, outcome pf preg | | | | | 23d. Date of deli | very |
| death ce attendi | cial | in the past 12 months? 1 ☐ Yes 2 ☐ No | 1□Live birth 2□Fe 4□Pregnant at time of | | 3 ☐ Ectopic pregnand 5 ☐ Other (specify) _ | су | | Month | Day Year |
| The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit | Physician | 9 Unknown | 9□Unknown | | | | | | |
| that ned b | | Part II. Other significant conditions | contributing to death but not re | sulting in th | ne underlying cause gi | ven in Part I. | 23e. Did to | bacco use contribute to | the cause of death? |
| quire: | d by | | | | | | 1 □ Y | es 2□No 3□Pr | obably hknown |
| w require s been sign | Completed | | | | | | 24a. Was a | an 24b. Were au | topsy findings available completion of cause of |
| The lav te has age 2 | ᇤ | | | | | | autops perfor | med? death? | completion of cause of |
| _ ~ ~ ~ ~ · | | | | | | | 1□ Yes | 2∏No 1 ☐ Yes | 2 □ No |
| an: | au l | 25. Was case referred to medical | | 26. Place of Death (Check only one) | | | | | |
| ysician: s certifice director, p | o Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No | Hospital: 1 ☐ Inpatient 2 | ER/Outpa | atient 3 DOA Ot | hor. | | | 2 □ No |
| g Physician: er this certifics | To Be | examiner? 1 Yes 2 No 27. Manner of Death | 28a. Date of Injury | 28b. Tim | ne of 28c. Inju | her: 4 🗆 Nursing | Home 5 🕅 Resid | ne) ence 6 □Other (Specower) ow injury occurred | |
| nding Physician: ath. rr: After this certifics te funeral director, p | To Be | examiner? 1 Yes 2 No 27. Manner of Death Thattural 5 Pending 2 Accident investigatio | 28a. Date of Injury (Month, Day Year) | <u> </u> | ne of 28c. Injury | her: 4 🗆 Nursing | Home 5 🕅 Resid | ence 6 □Other (Spe | |
| Attending Physician: ar death. ector: After this certifice by the funeral director. | To Be | examiner? 1 □ Yes 2 □ No 27. Manner of Death □ Matural 5 □ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Tim Inju | ne of 28c. Injury Wo | her: 4 Nursing ury at ork? Yes 2 No | Home 5 🕅 Residence 28d. Describe he | ence 6 Other (Specow injury occurred | cify) |
| lal or Attending Physician: The I s after death. The I all Director: After this certificate he ed in by the funeral director, page | To Be | examiner? 1 Yes 2 No 27. Manner of Death Shatural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b | 28a. Date of Injury (Month, Day Year) | 28b. Tim Inju | ne of 28c. Injury Wo | her: 4 Nursing ury at ork? Yes 2 No | Home 5 🕅 Residence 128d. Describe he | ence 6 Other (Specow injury occurred | cify) |
| the Hospital or Attending Physician: nin 24 hours after death. the Funeral Director: After this certifica | o Be | examiner? 1 Yes 2 No 27. Manner of Death Shatural 5 Pending investigatio 3 Suicide 6 Could not b 4 Homicide determined | 28a. Date of Injury (Month, Day Year) | 28b. Tim Inju | and the of the o | her: 4 Nursing Iry at fr? Yes 2 No | Home 5 N Residence Residence Residence See See See See See See See See See S | ence 6 Other (Specow injury occurred treet and Number or Run, State) | cify) ural Route Number, |

Division or Vital Records. P.O. Box 68760.

Krishan Mathur, M.D. 20646 31. Date filed (Month, Day, Year)

State Registrar

FEB 0 6 2008

William E Warren Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 Physician Day 0 William Edward Warren 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine Nico Coastul Hospice Oth MICO lisbury ake 20 If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours Min. 1 X M 2 □ F 214-32-5709 84 Director 6/3/1923 Maryland Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ¥Yes 2 ☐ No Director Maryland Wicomico Parsonsburg 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? ö 32786 Powell St. 21849 IISA or items 23a Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 721 than Elementary/Secondary (0-12) College (1-4or 5+) <u>technician</u> utility Department of Health and Mental Hygie Important: If Item 27 Is marked other i any Injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Edwin Warren Margaret Bratten ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Warren/wife 32786 Powell St., Parsonsburg, MD 21849 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/11/08 Jerusalem Cemetery Parsonsburg, MD permit. 22. Name and Address of Facility
Holloway Funeral Home Professional Association Signature of Funeral Service Licensee avid A. Compron CFSP 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CHRONIC OBSTRUCTIVE PULMONRY /Medical Due to (or as a consequence of): Examiner DZMBNTIA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the death certificate be executed and burial-tra Due to (or as a consequence of) physician Physician/Medical the as attending p IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9☐Unknown 9 Unknown ģ signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No has page 2 autopsy performed? this certificate 1□ Yes 2XNo or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 7 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1 Natural 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.
To the Funeral Director: All completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BE, 2005 2410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COASTAL POBOX1733 SALISBUMP GHUMAN WARLS up 21802 31. Date filed (Month, Day, Year) FEB 0 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and **Examiner** NIOMIC REGIONAL If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Social Security Number Days **Funeral** Min. Months Hours 1 🗌 M -32-842 -20-Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number eet Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Specify. Baltimore, Maryland 21215-0036 100 Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. # 40 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State Horntown, UA, 23395 2 Funeral Hon ice License md. 2185 BOX331 POCOMOKE e or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1□ Yes 2 2 certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 28d. Describe how injury occurred Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of eath funeral 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death. filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a
To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only onel and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 500 death (Item 23a) (Type, Print) 30. Name a1 of son who completed cause SIMONA 31. Date filed (Month, Pay Year) State 2008 Registrar

| | | | For State Registrar | ate of Maryland | | artment of F ctificate of | | | 100 | 008 | 05194 |
|-------------------|---|---------------------|---|---|-----------------------------|---|--|---------------------------------------|-------------------------------|--|--|
| | Dhysis | | 1. Decedent's Name (First, Middle, Last) | 1 / 1 - 1 | | | | 2. Date of De | ath Day _ | Vear | 3. Time of Death |
| Gra. | Physic /Medi | cal | KUBY Klizabet | | tin | | r Location of Death | Februa | | 2 0008 | 12:00 AM |
| | Exami | ner | 4a. Facility Name (If not institution, give street Wicomico Nursing | | | Salish | | | | nty of Death | |
| | Funeral Director | | 5. Social Security Number 215-14-3877 Usual Residence of Decedent | 7. Age (In yrs. las | t birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Bir (Month, Da | ıy, y ear) | 9. Birth | place (State or Foreign intry) Md |
| | ryland how at | | 10a. State 10b. County | | Town or Lo | | | | <u> </u> | | 10d. Inside City Limits |
| | he Ma 28a-f s | ectol | Md Wicomid | o Sal | isbu | | | | 10g. Citizen o | £14/h = 4 O = | 1 Yes 2 No |
| | h with 3a or | al Dir | 518 Winder St | | | 10f. Zip Code | 1 | | USA | ii wilat Gou | nuy: |
| 36 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral Director | 11. Marital Status 12. W. 1 Never Married 2 Married 1 | as Decedent Ever in U.S. med Forces? Yes 2 No res, Give ar or Dates: | | | lispanic Origin? (Span, Mexican, Puerto | pecify Yes or No Rican, etc.) | 14. R B | ace - Americack, White, | |
| 215-0036 | 72 hour natural | ted t | 15. Decedent's Education (Specify only highest grade com | 1 | 16a. Deced | lent's Usual Occup | ation | vina | 16b. Kind of | Business/In | dustry |
| | within 7 | Completed | Elementary/Secondary (0-12) | ellege (1-4or 5+) | 11 | ne ma Ko | during most of work d) o - | ang | Hou | isek | eeping |
| ld 21 | e filed within the Hygiene. other than vent, the M | Be Co | 17. Father's Name (First, Middle, Last) | | 11011 | rie friu no | 18. Mother's Nam | e (First, Middle | , Maiden Surn | ame) | |
| Maryland | should be ind Mental marked o | To | EMORY TOWNSEN | · · · · · · · · · · · · · · · · · · · | | | DAISY | | | | ENS |
| Mar | and 2 sho ealth and n 27 is mo | | 19a. Informant's Name/Relationship (Type. Pr. DAISEY SPENCE - C | laughter ! | 19b. Mailin (///) (| g Address (Street | Salis by | ral Route Numb Y II .かん | er, City or Tow 2180 | | o Code) |
| ore, | permit. Pages 1 and 3 Department of Health Important: If Item 27 any Injury or other tra once. | | 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Remove | ol from Stato | retery, crem | natory or other plat | · · | . 1 | 20c. Location | | own, State |
| Baltimore, | it. Pag intment intant: injury c | | 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee | St. N | lary's | Church C | em. 2-6 | 1-08 | Princ | ess a | wire, md |
| Ba | permi Depar Impor any Ir | < | THE STREET | cott | 1 | Name and Addre | Smith IAL Hom | 91 | 7 W I SA | LISBU | olla st ry, md 2180 |
| le le | | | 23a. Part1. Ever the dise so, or complication shock, or wart failure. List only one cau | s that caused the death. se on each line. | Do not ente | | the state of the s | | rrest, | | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause The disease or condition resulting in death) | A SCVD Due to (or as a consequer | non offi | | | | | | Onset and Death |
| | Examiner | | | oue to (of as a conseque) | ice oi). | | | | | | |
| 100 | ted sit | Examiner | cause. Enter Underlying | Due to (or as a consequer | nce of): | | | | | | |
| ó | execuran and rial-tran | | that initiated events | Due to (or as a consequer | nce of): | | | | | | |
| 68760, | icate be executed physician and s the burial-transit | edical | d | | | | | | | | |
| Box. | ath certif attending for use as | Physician/Me | in the past 12 mopths? | res, outcome pf pregnanc □Live birth 2 □ Fetal d □Pregnant at time of dea □Unknown | eath 3 | Ectopic pregnancy Other (specify) | | | I . | Date of deliv | ery Day Year |
| s, P.O | res that the de igned by the be detached | by Ph | Part II. Other significant conditions contributi | - | ng in the ur | nderlying cause giv | en in Part I. | 23e. Did 1 | obacco use co | ntribute to t | he cause of death? |
| ords | w require been sig should b | | MALNUTRITION | J · | | | | 1 🗆 | Yes 2 No | 3 ☐ Pro | bably 4 dnknown |
| or Vital Records, | sician: The law certificate has b rector, page 2 st | Completed | | | | | | 24a. Was auto perfo 1∐ Yes | | b. Were auto prior to co death? 1 ☐ Yes | opsy findings available impletion of cause of |
| r Vit | ysiciar is certif directo | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospita | ıl: 1 | R/Outpatien | t 3 DOA Oth | 26. Place of Dear | | |)ther (Speci | fv) |
| 0 U | ding Ph h. After thi funeral | | 27. Manner of Death 28a | Date of Injury (Month, Day Year) | Bb. Time of Injury | 28c. Injur Wor | y at k? | 28d. Describe | how injury occ | urred | ,,, |
| Division | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer | Certification: | 2 Accident investigation | e. Place of injury - At home building, etc. (Specify) | e, farm, stre | | Yes 2□No | 28f. Location (City or To | Street and Nur wn, State) | mber or Rur | al Route Number, |
| | e Hospita 124 hours e Funera letely filled | Medical C | 29a. Certifier (Check only one) | To the best of my knowled the basis of examination manner stated. | edge, death n and/or inv | occurred at the tirvestigation, in my o | me, date and place opinion, death occu | , and due to the rred at the time, | cause(s) and date and plac | manner as se, and due | stated, to the cause(s) |
| | To the within To the comp | Me | 29b. Signature and title of certifier | | | 29c. Licens | | | 29d. Date sign | | >- |
| | 300 | | Jeline | | 0-1/7 | | 3199. | | 451 | 2005 | - |
| | 0~ | | 30. Name and address of person who complete Yogesh Vohra MD | ed cause of death (item 2) 614 Easte | , , , , , | · | Salisbu | ry MD | 2180 | 4 | |
| F | Sta Regist | | 31. Date filed (Month, Day, Year) FEB 0 7 2008 | 32 Registrar's Signatur | e . | | - | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene') Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Year 03 06:35 A M 3008 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltmore Baltimore City miversity 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, April 5 6. Sex Ag (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 1□M 2⊠F Months Hours 1949 58 161-40-1075 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminer must be notified at 1 ☐ Yes 2 No Washington Hagerstown Director MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21740 19748 Longmeadow Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. Municipal Government Secretarial 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Doris J. Zembower Eugene R. Dreyer ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19748 Longmeadow Rd. Hagerstown, Md. 21740 James H. Wyckoff/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rest Haven Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 2/14/08 Hagerstown, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Zimmerman And Son Funeral Home 21. Signature of Funeral Service Licensee 45 S. Carlisle St. Greencastle Pa. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumo /Medical Due to (or as a consequence of): ogenous Leukema Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner death certificate be executed and Due to (or as a consequence of) the burial-Box 68760, physician Physician/Medical as 1 attending p for use as IF FEMALE 23c. if yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 Fetal death 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. 1 ☐ Yes 2 ☐ No the 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, à 2 No 3 Probably 4 Donknown 1 TYes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? page The 1 Ves 2 □ No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No ٩ 1 🖺 Yes 1 Inpatient After this funeral dire 2 | ER/Outpatient 3 DOA Division or 28a. Date of Injury (Month, Day Year) 27. Man of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 ☐ Pending investigation 1 Natural Injury 1 ∏Yes 2 ∏No 2 Accident within 24 hours after death

To the Funeral Director:.
completely filled in by the I 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Greene St.

Baltimore

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

32. Registrar's Signature

S.

Benni

31. Date filed (Month, Day, Year) 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year
FEBRUARY 13 2008 **Physician** CARLTON E. WILLIS 3:00 p^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 134 Cedarwood Dr. Kent Galena If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Oct 13, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1920 1 M 2 ☐ F 216-28-5866 87 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ∑Yes 2 No Director MD Kent Galena 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 134 Cedarwood Dr. 21635 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. within 72 hours after 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2X Married 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify 2 3 ☐ Widowed 4 ☐ Divorced WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Aero Space Elementary/Secondary (0-12) College (1-4or 5+) Property Manager 12 Engineering es 1 and 2 should be filed w of Health and Mental Hygier fitem 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Van Willis Blanch Bryant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Willis (wife) 134 Cedarwood Dr. Galena, MD. 21635 permit. Pages 1 a
Department of He
Important: if item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Galena Cemetery 2/17/08 Galena, MD. 4 Donation 5 Dother (Specify) 21. Signature of Fun Sen Galena Funeral Home of Stephen L Schaech 118 West Cross St. Galena, MD. 21635 M00510 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allure. List only one cause on each line. Immediate Cause r inal disease or condition resulting in deat Physician /Medical Due to (or as a con eq. , ce of) Examiner au Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-transit and Los to Ca Due to (or as consequence of) Box 68760, attending physician for use as the buria Physician/Medical 23c. if yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the a I be detached f □Yes 2□No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ X No 1 ☐ Yes 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has perfo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this funeral (27. Manner of Death
Natural
Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

FEB 2

223

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

MID

32. Registrar's Signature

IN COO NA MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 25 per dr., 9877, 03/21/08dbb Reg. No. 1 - For State Registra 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** ATES harles Edwared 04:17 AM 02 2008 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HICOMICO Salisbyry Regional 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 X M 2 □ F 900-32-3112 9-15-1956 5 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rai", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No HARTLEY Director KEN d)e 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 19953 5017 HALL USA OWN Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 2 1\no If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White Completed by 3 ☐ Widowed 4 € Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) d 2 should be filed within 7; th and Mental Hygiene. 7 **is marked other than "n** College (1-4or 5+) Elementary/Secondary (0-12) NONE LADDRER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be hurch -PERAINE _AKE ပ and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type. Print) oNathon hART SON Ollins Rd EOLEN H822 24938 20b. Place of Disposition (Name of cemetery, crematory or other place)

SALS DURY REMARKS 20c. Location - City or Town, State Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 □Removal from State -8-08 Alisburg 21. Signature of Funeral Service Licenses 22. Name and Address of acility Glade STEWAR HOME FUNERA! Approximate Interval Between Onset and Death 23a. Part1. Enter the Jsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ζ-Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-tran-Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certification: To Be Completed by 3 Probably 4.☐Unknown 1 🗌 Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No harles Vates 24a. Was an certificate has be irector, page 2 s autopsy perform 1 Yes 2 2 No or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Beath 5 Pending investigation 1 Natural Injury 1 🗌 Yes 2 Accident the within 24 hours after deatl

To the Funeral Director:
completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specity) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ★ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**To the physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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**To the physician of the physician occurred at the time, date and place, and due to the cause(s) and manner as stated.

**To the physician occurred at the physician occurred at the time, date and place, and due to the cause(s) and manner as stated.

**To the physician occurred at the physician occurred at the time, date and place at the physician occurred at the physicia 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tile of certifier 29c. License number of death (Item 23a) (Type, Print) 30. Name and address of person

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

FEB 0 8 2008

900-32-3112

MD

32. Refistrar's Signature

SALISBURY Md.

4b. City. Town, or Location of Death

Mount Airy

Day

February 6, 2008

Year)

4c. County of Death

Carroll

7:00A M

Birthplace (State or Foreign Country)

10d. Inside City Limits

20872

Approximate Interval Between Onset and Death

Year

Day

tohead

Manchester, Maryland

1 ☐ Yes 2 X No

Russia

White

| | | | | Plea | se | Туре о | | | | |
|--------------------------------|--|-------------------------------------|--|------------------------------------|---------|-----------------|-----------|--|--|--|
| | | | For State Registrar | | | State | of Ma | | | |
| | | | 1. Decedent's Name | (First, Midd | le, Las | it) | | | | |
| e a | Physicia /Medic | | | Ivan | ı. | Yak | uche | | | |
| | Examin | | 4a. Facility Name (If | not institutio | n, give | | | | | |
| 1 | | | 7935 Dog | wood 1 | Dri | Ve | | | | |
| | Funeral | | 5. Social Security No | | 6. S | ex | 7. Ag | | | |
| , j | Director | | 579-42-5 | 175 | 1- | X M 2□ F | | | | |
| | Director | | Usual Residence of | Decedent | | | | | | |
| | and | | 10a. State | 10b. County | , | | | | | |
| | Maryli -f sho fied at | tor | Maryland | Carro | 011 | | | | | |
| | the 283 | rec | 10e. Street and Nun | | | | | | | |
| | 3a or | i Di | 7935 Dog | wood 1 | Dri | ve | | | | |
| | ns 2 mus | era | 11, Marital Status | | | 12. Was De | ecedent | | | |
| | iter d | 'n | 1 ☐ Never Marri | ed 2□Mai | rried | 1 🗆 Ye | Forces? | | | |
| 036 | urs af al', or Exami | by F | _ | 4 Divorced | | If Yes, Year or | Give | | | |
| 2-0 | 72 ho natur dical | eted | 15. Decedent's Education (Specify only highest grade completed) | | | | | | | |
| 2121 | d within giene. r than " the Me | To Be Completed by Funeral Director | Elementary/Secon | | | | (1-4or | | | |
| ğ | e filec al Hyg othe vent, | Se C | 17. Father's Name (| First, Middle | , Last) | | | | | |
| <u>la</u> | uld by Menta Irked | T0 E | Unkno | own | | | | | | |
| ar) | sho sund f | | 19a. Informant's Na | me/Relation | ship (| Type. Print) | | | | |
| Σ | alth a | | Edward Iv | an Ya | kuc | hev - | Son | | | |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 20a. Method of Disp 1 ☐ Burial 2 4 ☐ Donation | osition Cremation 5 Other (| | Removal fro | m State | | | |
| Balti | permit. Departri Importa any inju | | 21. Signature of Au | ineral Service | Licer | nsee Vi | lli | | | |
| r. | 34. | | 23a. Part1. Enter the shock, or hea | ne disease, o | or com | plications tha | at cause | | | |
| | Physician /Medical | | Immediate Cause (disease or condition resulting in death) | Final | | a. 6 3 | to (or as | | | |
| | Examiner | | Sequentially list | nditions | | b | (5) 00 | | | |
| di | P is | edical Examiner | Sequentially list colif any, leading to im | nmediate | Į | Due | to (or as | | | |
| | ficate be executed physician and the burial-transit | am | mai inilialed evenis | • | | c | | | | |
| oʻ | an al | Ä | resulting in death) I | _asi | | Due | to (or as | | | |
| 9/ | icate be execu physician and s the burial-tra | ca | | | | d | | | | |
| 89 | ificati g phy as the | edi | | | | | | | | |

Yakuchev

Age (In vrs. last birthday)

attending for use a ed by the a After

ne Hospital or Attendi n 24 hours after death. ne Funeral Director; A death. To the To the within

Division or Vital Records, P.O. Box

If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 1X M 2□ F 84 Oct. 10, 1923 579-42-5175 ual Residence of Decedent 10c. City. Town or Location 10b. County Mount Airy aryland Carroll 10g, Citizen of What Country? 10f. Zip Code e. Street and Number 21771 U.S.A. 7935 Dogwood Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ XNo Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automobile 12 Mechanic 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) a. Informant's Name/Relationship (Type. Print) Catonsville, Maryland 21228 dward Ivan Yakuchev - Son 14 Old Dominion Court, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Metropolitan Crematorium 2/7/08 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) Signature of Auneral Services Licensee . Molesworth-Williams P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland Kovert 3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nmediate Cause (Final sease or condition ohed sease or conditions sulting in death) Due to (or as a consequence of): equentially list conditions, any, leading to immediate succ. Energy Uncertying ause (Disease or injury lat initiated events sulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: Physician/M 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) Found 2 10600 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: to Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 637A Selfint 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7935 Dogwood DR 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 Homicide MACYLAND KES IDENCE MT. AIRY MARYLAND

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 6, 2008 00519 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Herbert P. Henderson

FEB 0 8

2008

31. Date filed (Month, Day, Year)

M.D.

32. Registrar's Signature

2973 Manchester Road,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death EBRUARY **Physician** 6 Twin B Baby Boy Ben /Medical Facility Name (If not institution 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 6, 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Maryland Director none Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Ca. State r 28a-f show notified at 1√2Yes 2□No Director MD Baltimore death with the Mc 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 7 4414 Belair Road 21206 Funeral USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 7 Is marked other than "natural", or items traumatic event, the Medical Examiner m Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If item 27 Is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 TNever Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none none none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Patrick Shaffer Tiffany Ben ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) The Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation Department o Important: If i any injury or once, ō 3 □Removal from State 4□Donation 5★Other(Specify) in state Licensee de, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pant Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Paset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Physician/Medical Examiner The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 2[**X** No 1 Tes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was a... autopsy performed? Yes 211 No pate has page 2 s or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 1 Tyes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation (Month, Day Year) 1 Natural 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific

K3H

State Registrar 31. Date filed (Month

DHMH 17 Rev 1/2001

32. Registrar's Signature

Reet BALTIMORE, MARYLAND 2128

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month William M. Biddle 02-12-2008 600 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fallston Harford 807 Dellwood Dr. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | April, 20, 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 411-14-9949 87 Director Tenn. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Harford MD 1 ☐ Yes 2 No Director Fallston 10e Street and Number 807 Dellwood Dr. 10f. Zip Code 10g. Citizen of What Country? 21047 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? V☐ Yes 2☐ No If Yes, Give Year or Dates:1942-1946 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Engineer Boiler Repair 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert N. Biddle (Unknown) Louvena ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 807 Dellwood Dr. Fallston, MD 21047 Ocena G. Snyder - Daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition Conowingo Baptist Ch. tX Burial 2 ☐ Cremation 3 ☐ Removal from State 2/15/2008 Conowingo, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySchimunek Funeral Home of Bel_Air 610 W. MacPhail Rd. Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Yo Candia Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, the state of t Due to (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the as for use IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) ned by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be d Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed certificate 1 Yes 2 No or Attending Physiclan: director. Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation after death. 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

29b. Signature and title of certifier

M. ALABRASH,

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

29c. License number D37612

1601 South Tollgie Rd Bel AIR MO

and manner stated.

32. Régistrar's Signature

Section of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month /Medical 4a. Facility Name (If not institution, give street and n 4b. City, Town, or Location of Death 4c. County of Death Examiner (Janteur Parks.14 Boutsmany. (Tinesis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🖾 F Yrs. 89 Director 217-40-2011 Feb 16, 1919 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County fshow ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director MD Parkville Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code with USA Funeral 6 Bexleigh Court Apt. 304 21234 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner and Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kathrine Kremer Joe Ajello ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>Kathleen Beck</u> 6 Bexleigh Ct. Apt. 304 Parkville MD 21234 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【ICremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02-20-2008 | Baltimore MD Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. Edg 9705 Belair Rd Nottingham MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzeherner, **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the SS ed by the attending detached for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown HIN Completed CHE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy perform certificate 25. Was case referred to medical examiner? 1∐ Yes 2 No To the Hospital or Attending Physician: Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | No P 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

Registrar

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Wends

Kluz

Kloese

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6741 M Charles St

32. Registrar's Signature

29c. License number

Sut 4202

31295

Tousa

29d. Date signed (Month, Day, Year)

2/18/05

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Mary Catherine Banz 21 02 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Raltimore ore dala Sugre 8. Date of Birth (Month, Day, Year)
July 17,1912 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (In yrs. last birthday, Under 1 **Funeral** Days Hours Min. Months 1 ☐ M 2 🔀 F 219 50 7336 95 Director Maryland Usual Residence of Decedent ould be filed within 72 hours after death with the Maryland Mental Hygiene.

Meter than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 TYes 28 No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 807 Myrth Avenue 21221 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian Black White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No White Kanz Mary altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) Owner/ Operator Hardware Store 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Menta George Streckfus Mary Foley P and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health sem 27 | Joseph Banz Jr. 8107 Callo Lane Baltimore, Maryland 21237 permit. Pages 1 and Department of Healt Important: If Item 2: any Injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/25/2008 Oak Lawn Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) rature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Nyocardia Physician ntarction disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Bleedin Kectal Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ō in the past 12 months? 4□Pregnant at time of death 9□Unknown 5 Other (specify) signed by the a 2 🗆 No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law has page 2 autopsy certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 261 No 1 Inpatient 1 ☐ Yes 2 ☐ ER/Outpatient 3 ☐ DOA P this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier KES 00000 30. Name and address of person who completed duse of death (Item 23a) (Type, Print) 10 Raltimore 9000 Fran Dr. Maytee Boonyaper dee 32 Registrar's Signature State 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death February 19,2008 **Physician** 10:40 A.M Janine Louise Bradley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore County Timonium 4 Roundridge Road 8. Date of Birth (Month, Day, Year) Jan • 01, 1918 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months 1□M 2∯F Baltimore, MD. 90 216-01-7884 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Baltimore County Timonium Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Examiner must be no once. United States 21093 4 Roundridge Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peter Murawski Catherine Murawski 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6 Upland Road unit J5 Baltimore, Maryland 21210 (Son) Mr. Donald A. Bradley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel Feb.20,2008 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Peaceful Alternatives Funeral&Cremation Ctr., P.A 2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service License 2 Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Immediate Cause (Final Physician 4-2tion disease or condition resulting in death) /Medical a consequence of): Examiner sphas; Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Supranualea that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year in the past 12 months? Day 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify) the ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy perform certificate 2 No 1 ☐ Yes 1 Yes 2 1 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 4 Residence 1 ☐ Yes Hospital: 2 NO 3□ DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 this 27. Mann Death 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: within 24 hours after death.

To the Funeral Director: After of the funeral completely filled in by the funeral Natural (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 000358+7 February 19, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 18 Lutherville, Maryland 21093 1205 York Road Elizabeth Lucas, M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB21 2008 Registrar

| Division or Vital Records, P.O. Box 68760, | | Baltimore, Maryland 21215-0036 |
|---|-------------------|---|
| all or Attending Physician: The law requires that the death certificate be executed as after death. | Phy /M Exa | permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hydiene |
| Director: After this certificate has been signed by the attending physician and | sic edi ımi | Important: If Item 27 is marked other than "natural", or items 2 |

| | | | Please | Type or Prin | | | | | | - | | gible. | | |
|---|------------------|--|---|--|----------------|-----------------------|--|-----------------------------|-------------------------------|--|----------------|----------------------|--|---------|
| | | For State | | State of Ma | aryland | | artment of H <i>rtificate of</i> | | ınd Men | | - 7 | 008 | 052 | 0.5 |
| 1 k | | 1 - State Registrar 1. Decedent's Name | (First, Middle, La | est) | | | Tillicate of | Dealli | 2. | Date of Deat | eg. No. 5 h | , | 3. Time of D | eath |
| Physici /Medic | | | | Ruth | В1 | ando | n | | F | e www. | 1 16 (| anno | 1:00 | РМ |
| Examin | | 4a. Facility Name (If I | not institution, giv | e street and number) | | | 4b. City, Town, o | or Location of | | (| 4c. Cou | inty of Deat | h | |
| Funeral | | 4320 5. Social Security Nu | Clarewa | AY Sex 7. Age | e (In yrs. la: | st birthday) | Balto If Under 1 Year | If Under 2 | 24 Hrs. 8. I | Date of Birth | | N/A 9. Birtl | hplace (State or I | Foreian |
| Director | 1 | 214-24- | | 1□M 2∏F | 83 | | Months Days | Hours | | Month, Day, $1-20-$ | | Co | untry) MD | |
| and w | | Usual Residence of D 10a. State | Decedent 10b. County | | 10c. City, | Town or Lo | ocation | | | | | | 10d. Inside City | Limits |
| Mary a-f sho iffed a | tor | MD | | N/A | В | alti | more | | | | | | X [□] Yes 2 | 2 □ No |
| or 28 | Director | 10e. Street and Num | ber | | | | 10f. Zip Code | | | 10 | g. Citizen | of What Co | untry? | |
| eath v ns 23a must | Funeral | 4320 C | lareway | 12. Was Decedent I | ver in U.S. | 13. | 212 Was Decedent of F | | nin? (Snecify | USA Yes or No- 14. Race - American Indian, | | | rican Indian. | |
| after d or iten niner | | 1 ☐ Never Marrie | d 2□ Married | Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give | | I | Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No | | , Puerto Rica | ın, etc.) | | Black, White | e, etc. | |
| hours ural", al Exag | d by | 3 X Widowed 4 | | Year or Dates: | | | | | | | | | Black | |
| iin 72 n "nat Aedica | Completed | (Specif | 15. Decedent's E | ducation ade completed) College (1-4or 5 | - | (Give life. | dent's Usual Occup kind of work done DO NOT use retire | pation during most d) | of working | | 16b. Kina (| of Business/ | ^{Industry} Un | ık |
| ed with | Com | 12th g | rade | | N/A | | Grocer | | | | | | | |
| ntal Hi ed oth eveni | Be | 17. Father's Name (F | | | | | | ļ | r's Name <i>(Fil</i> crice | rst, Middle, N | 1aiden Sur | rname) | | |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | ဍ | 19a. Informant's Nar | | | | 19b. Maili | ng Address (Street | | | oute Number, | City or To | wn, State, Z | Zip Code) | |
| and 2 ealth a n 27 is er trau | | Naomi Br | own - | Daughter | - | 1631 | Stonew | ood I | Road | Balti | more | ,_MD | 21239 | |
| Pages 1 nent of He int; if Iten iny or oth | | 20a. Method of Dispo 1 ☑ Burial 2 □ | | Removal from State | cer | netery, cre | osition (Name of matory or other pla | | Date | 1. | | on - City or | | |
| urtmen urtant; ortant; | | 4 Donation 5 | 5 Other (Specia | | Kin | | morial 2. Name and Addre | i_ | | | | alls | town, M | 1D |
| permit. Departr Imports any Inji | | 15 | confu Me | | | | | | ' Mar North | ch Ea Aven | | Balto | 2 1 2, MD | .202 |
| | | 23a. Part1. Enter the shock, or heart | e disease, or com t failure. List only | nplications that caused one cause on each lir | the death. | Do not en | | | | | 17 | | Approximate Interval Between | |
| Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) Onset and Death Onset and Death Onset and Death Onset and Death | | | | | | | | | | | | |
| Examiner | | | - | Lue to () ras | a conseque | noe of) | | | | | | • | 1-2 We | eks |
| | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | | | | | | | | | | | |
| oe executed clan and ourial-transit | Examiner | Cause (Directlying Cause (Disease or injury that initiated events could be considered to the country of the cou | | | | | | | | | | | | |
| e be ex siclan s buria | I — I | · | | | | | | | | | | | | |
| The law requires that the death certificate be ate has been signed by the attending physicla page 2 should be detached for use as the bur | Physician/Medica | IF FEMALE: | | - V. | | | | | | | | | | |
| ath ce attendi for use | ian/I | 23b. Was decedent in the past 12 m | | 23c. If yes, outcome 1 □Live birth 4 □ Pregnant at | 2 🗌 Fetal o | death 3 | ☐Ectopic pregnanc | ;у | | | 23d. | Date of del Month | | ear |
| the de | nysic | 1 ☐ Yes 2 ☐ 9 ☐ Unknown | No | 9□Unknown | ume or dea | aui 5[| Other (specify) _ | | | | | | | |
| w requires that the debeen signed by the should be detached | by P | Part II. Other signific | cant conditions | contributing to death bu | ut not result | ing in the u | nderlying cause giv | ven in Part I. | | 23e. Did tob | acco use | contribute to | the cause of dea | |
| requir seen si hould | eted | | | | | | | | - | 1 □ Y€ | | lo 3∏Pr | (| |
| he law has b | Completed | | | | | | | | | 24a. Was at autops perform | У | | topsy findings av completion of cau | |
| an: TI tificate tor, pa | Be Co | 25. Was çase referre | ed to medical | | | | | 26. Place | of Death (C) | 1□ Yes 2 | No | 1 ☐ Yes | 2 No | |
| hysici this cer al direc | To B | examiner? | 10 | Hospital: 1 ☐ Inpatie | | R/Outpatie | III OLI DOX | | rsing Home | 5 Aeside | nce 6 | Other (Spe | cify) | |
| ding P. After (| ion: | 27. Manner of Death 1 Death | 5 ☐ Pending investigatio | 28a. Date of Inju (Month, Day | | 28b. Time o Injury | Wo | ıryat ırk?]Yes 2∐1 | | Describe ho | w injury o | ccurred | | |
| Atten ir deat ector: by the | Certification: | 2 Accident 3 Suicide 4 Homicide | 6 Could not be determined | e ge Place of init | ry - At hom | ne, farm, st | reet, factory, office | | | | | umber or Ru | ural Route Numb | er, |
| ital or Irs afte Iral Dir Iled in | | | 160 | | | | | | | City or Town | | | | |
| To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: | edical | 29a. Certifier (Check only one) | | hysician: To the best of miner: On the basis of and manner sta | examination | | | | | | | | | |
| To th withir | Me | 29b. Signature and to | itle of certifier | Tup | lec | xen | 29c. Licens | | 661 | 2: f | 9d. Date si | igned (Mont | 1914 2 | 800 |
| 37 | | 30. Name and addre | ss of person who | completed cause of d | eath (Item 2 | 23a) (Type, | Baltin | E. | Ko | 821 | 23 | 9.0 | | |
| Sta | ite | 31. Date filed (Month | n, Day, Year) | 32. Alegistra | ar's Signatu | ire | with the same | | | | | | | |
| Registr | ar | F | EB 2 1 2 | 2008 | as A | All | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Eburary **Physician** 200 Sandra Ε. Barranco /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Dea Examiner Kosedale al Square 8. Date of Birth (Month, Day, Year) July 16,1947 If Under 1 Year | If Under 24 Hrs. 6. Sex (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 212-46-5577 1 □ M 2 □ ¥ Yrs. 60 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. 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Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Riley Adey Shirley Tracy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barranco /husband Joseph Congressinal Court Balto. MD 21220 1 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition 20c. Location - City or Town, State crematory or other place) w Crematory (02/21/08) 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3 ☐Removal from State Bayview Baltimore, MD. Other (Specify) 22. Name and Address of Facility 21. Signature of Fune Service Licenses 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 aliso fons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) eta **Physician** ancer /Medical Due to (cr as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≨</u> 1 X Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe res 2 Hospital or Attending Physician: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature a

Division or Vital Records, P.O. Box 68760, within 24 hours a To the Funeral I the

State Registrar DR. VASILIADES

29c. License number

29d. Date signed (Month, Day, Year)

DO064755

Square Drive

108

pleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 74, 2008 **Physician** Camella 10.30 A M Bongiorno /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3112 Weaver Avenue Baltimore 7. Age (In yrs. last birthday) 83 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/03/1924 9. Birthplace (State or Foreign Social Security Number 219–18–7678 **Funeral** Days Mary I and 1 □ M 2 🗓 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hydene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Baltimore 1 XYes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21214 U.S.A. 3112 Weaver Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Worker Glen L. Martin 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Signorino Prestianni Bessie N. Bonsignor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3112 Weaver Avenue Baltimore, Maryland 21214 John Vincent Bongiorno - Husban¢ 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02/18/2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 5305 Harford Road Baltimore, Maryland 21214 € Funeral Serytca 22. Name and Address of Facility Leonard J. Ruck, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear bailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Ischemic disease /Medical Due to (or as a consequence of) Examiner Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) signed by the a 1 ☐ Yes 2 🛛 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy performed? Yes 2 🙀 No certificate 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Coertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Hilary Don, 31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D.

2008

and manner stated

D35102

29c. License number

29d. Date signed (Month, Day, Year)

February 19, 2008

| hysicia | | Decedent's Name (First, Middle, Last) | | | ment of H | | 2. Date of D | | 000 | 3. Time of Death |
|---|--|--|--|--|--|---|---|--|--|---|
| | an | EVELYN ANNET | TE | BL. | AKEN | EY | Month FEBRU | 1RY Day | Year 2008 | 200 A |
| Medic/ Examin | | 4a. Facility Name (If not institution, give street and nu | 1 | | | Location of Deat | | 4c. C | ounty of Death | 1 |
| LAGITIIII | CI | MANOR CARE RI | | | 100 | JSON | | 13 | | MORE |
| uneral | | 5. Social Security Number 6. Sex 1 ☐ M 2 ☐ F | 7. Age (In yrs. last i | N | f Under 1 Year Ionths Days | If Under 24 Hrs Hours Min. | (Month, D | ay, Year) | 9. Birth | nplace (State or Fore |
| irector | | 237-46-0201 | 74 | Yrs. | | | 01 10 | 34 | | NC |
| M II | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, To | own or Locat | ion | | | | | 10d. Inside City Lim |
| ind sh | tor | MD NA | Ва | altim | ore | | | | | 1 X Yes 2 ☐ I |
| r 28a | irec | 10e. Street and Number | | | 10f. Zip Code | | | | on of What Co | - |
| 23a o | al D | 2506 Edgecomb Circle | e North | | | .215 | | | U.S.A | |
| ems Er mi | Completed by Funeral Director | Amed F | | 13. Wa | s Decedent of H es, specify Cuba | ispanic Origin? (9 an, Mexican, Puer | Specify Yes or N to Rican, etc.) | 0- 14 | . Race - Amer Black, White | |
| i or h | F. | 1 Never Married 2 Married 1 Yes If Yes, G 3 Widowed 4 Voivorced Year or I | e ∏ No Sive | 1□ | Yes 2 No | Specify: | | s | pecity: B | lack |
| tural al Ex | ed b | 15. Decedent's Education | | 6a. Deceden | it's Usual Occup | ation | | 16b. Kind | of Business/ | |
| de dis | plet | (Specify only highest grade completed, |) | (Give kin | d of work done NOT use retired | during most of wo | orking | | | |
| the state | E O | 7th grade na | (1-4or 5+) | Don | nestic | Worker | | P | rivat | е |
| marked other than " umatic event, It's Wes | Be C | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Na | me (First, Middl | e, Maiden S | umame) | |
| arked atic e | 10 | Clarence McAllister | | | | Annie | | | | |
| le ma | | 19a. Informant's Name/Relationship (Type, Print) | | | | and Number or Fi | | | | ltimore |
| m 27 her tr | | Evelyn Owens-Daughte | | e of Dispositi | _ | | | | ation - City or | |
| If its | | 20a. Method of Disposition → Burial 2 M remation 3 □ Removal from | n State Met | ro cre | TELOL y | ce) 2/2 | 25 /2008 | | timor | |
| rtant | | Donation 5 ☐ Other (Specify) 1. Signature of Funeral Service Licensee | 11 | | - OTI | | 3700 | Dar | CIMOL | c, na |
| Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be indiffied at once. | 1 | MOLA C | MA | Mar 430 | lame and Addre | l West ash Ave | . Balt | imore | Md | 21215 |
| - 23 | \vdash | 23a, Part . Enter the disease, or complications that | caused the death. D | | | | | | | Approximate Interval Between |
| . aiaian | | shock, or heart failure. List only one cause on Immediate Cause (Final | | 115 | NOCA | 100.410 | 1 | | | Onset and Death |
| sician ledical | | disease or condition resulting in death) | 131/216 | 21//1- | | | | | | |
| aminer | | Due to | o (or as a consequent | nce of): | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 7-21/01 | 100/4 | | | |
| arminer. | | | o (or as a consequen | nce of): | <i>y</i> - C// | PRCINC | 70074 | | | |
| | ner | Sequentially list conditions, if any, leading to immediate Due to | o (or as a consequent | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 7-21/01 |) N /A | | | |
| | aminer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. | o (or as a consequenc | nce of): | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 7-2170 | 7/4 | | | |
| | i Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. | | nce of): | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 7421 00 |) M /4 | | | |
| nysician and he burial-transit | icai | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. | o (or as a consequenc | nce of): | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 7,421,00 |) M / A | | | |
| nysician and he burial-transit | edicai | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: Due to d. | o (or as a consequenc | nce of): | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 7421702 |) M / A | 23 | 3d. Date of del | livery |
| attending physician and for use as the burial-transit | edicai | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | o (or as a consequent | nce of): nce of): y sath 3 □E | ctopic pregnance | |) M / A | 23 | 3d. Date of del Month | |
| attending physician and for use as the burial-transit | edicai | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant 1.2 cause (Disease of Injury that initiated events of Injury that injury tha | o (or as a consequence of or as a consequence of pregnancy of birth 2 Fetal dearmant at time of death | nce of): nce of): y sath 3 □E | ctopic pregnanc | | 7 M / A | 23 | | |
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| is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit | Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 2 Other 10 Medical examiner? 1 Yes 2 No Hospital: 1 | o (or as a consequence of or as a consequence of pregnancy birth 2 Fetal degrant at time of death chown death but not resulting | y sath 3 End of the under | ctopic pregnanc: other (specify) _ erlying cause given | y ven in Part I. 26. Place of Diner: 4 Gursing | 23e. Did 1 [24a. Wh aui pei 1 [Yes eath (Check only Home 5] Re | I tobacco us Yes 2 Is an copsy formed? 2 In one) sidence 6 | Month e contribute to I No 3 Pr 24b. Were at prior to death? 1 Yes Other (Spe | Day Year to the cause of death robably 4 July 1 utopsy findings avai completion of cause 2 No |
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| or usefor. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit | Certification; To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 27. Manner of Death 28a. Dat (Mc of Mc of | o (or as a consequence of or as a consequence of pregnancy or birth 2 Fetal designant at time of death frown death but not resulting the death | nce of): y aath 3 E ch 5 C ng in the under NOutpatient Bb. Time of Injury e, farm, stree | ctopic pregnance. Other (specify) erlying cause give 3 DOA 28c. Inju Wo M 1 Dot, factory, office | yen in Part I. 26. Place of Doner: 4 Tursing ry at rk? 1 Yes 2 \sum No | 23e. Dic 1 24a. We aut per 1 7 Yes eath (Check only Home 5 7 Re 28d. Describ 28f. Location City or 7 | I tobacco us Yes 2 Is an oppy formed? 2 Yone) sidence 6 s how injury (Street and own, State) | Month e contribute to No 3 Pr 24b. Were au prior to death? 1 Yes Other (Spe occurred | Day Year to the cause of death robably 4 utopsy findings avail completion of cause 2 No activ) ural Route Number, |
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| 4 flours are report. After this certificate has been signed by the attending physician and Funeral Director. After this certificate has been signed by filled in by the funeral director, page 2 should be detached for use as the burial-transit | To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | o (or as a consequence of or as a consequence of pregnancy of birth 2 Fetal deignant at time of death shown death but not resulting the death | nce of): y aath 3 E ch 5 C ng in the under NOutpatient Bb. Time of Injury e, farm, stree | ctopic pregnance. Other (specify) erlying cause give 3 DOA 28c. Inju Wo M 1 Dot, factory, office | yen in Part I. 26. Place of Diner: 4 Jursing ry at rk? IYes 2 No | 23e. Dic 1 24a. We aut per 1 7 Yes eath (Check only Home 5 7 Re 28d. Describ 28f. Location City or 7 | I tobacco us Yes 2 Is an opsy formed? 2 No r one) sidence 6 s how injury (Street and own, State) le cause(s) a e, date and | Month e contribute to No 3 Pr 24b. Were au prior to death? 1 Yes Other (Spe occurred | Day Year to the cause of death robably 4 Luck utopsy findings avail completion of cause completion of cause completion of cause actify) ural Route Number, s stated. e to the cause(s) |
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| 4 flours are report. After this certificate has been signed by the attending physician and Funeral Director. After this certificate has been signed by filled in by the funeral director, page 2 should be detached for use as the burial-transit | edical Certification; To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | o (or as a consequence of or as a consequence of pregnancy or birth 2 Fetal degrant at time of death frown death but not resulting the control of the cont | y sath 3 E. h 5 C C C C C C C C C C C C C C C C C C | ctopic pregnance other (specify) erlying cause give 3 DOA 28c. Inju Wo M 1 t, factory, office coccurred at the ti stigation, in my 29c. Licent | yen in Part I. 26. Place of Diner: 4 Tursing ry at rk? I'ves 2 \sum No I'me, date and platopinion, death ocurse number | 23e. Dix 1 | I tobacco us Yes 2 Is an opsy formed? 2 Yone) sidence 6 e how injury (Street and own, State) The cause(s) a e, date and in the cause in the c | Month e contribute to I No 3 Pr 24b. Were at prior to death? 1 Yes Other (Spe occurred Number or Ri And manner at place, and due signed (Mont) | Day Year of the cause of death robably 4 |
| 4 flours are report. After this certificate has been signed by the attending physician and Funeral Director. After this certificate has been signed by filled in by the funeral director, page 2 should be detached for use as the burial-transit | edical Certification; To Be Completed by Physician/Medical | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo 9 Unknown Part II. Other significant conditions contributing to 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 27. Manner of Death 28a. Date 28a. Date 28a. Plant 28a. Plant | o (or as a consequence of or as a consequence of pregnancy or birth 2 Fetal degrant at time of death frown death but not resulting the control of the cont | ance of): y sath 3 E sh 5 C R Outpatient Bb. Time of Injury e, farm, stree edge, death of n and/or inve | ctopic pregnance other (specify) erlying cause give 3 DOA 28c. Inju Wo M 1 t, factory, office coccurred at the ti stigation, in my 29c. Licent | yen in Part I. 26. Place of Diner: 4 Tursing ry at rk? I'ves 2 \sum No I'me, date and platopinion, death ocurse number | 23e. Dix 1 | I tobacco us Yes 2 Is an opsy formed? 2 Yone) sidence 6 e how injury (Street and own, State) The cause(s) a e, date and in the cause in the c | Month e contribute to I No 3 Pr 24b. Were at prior to death? 1 Yes Other (Spe occurred Number or Ri And manner at place, and due signed (Mont) | Day Year the cause of death robably 4 Luck utopsy findings avail completion of cause 2 No wifty) ural Route Number, s stated. e to the cause(s) |

| | | | 1 - State of Mary | | rtificate of L | | Re | g. No. 2008 | | |
|---------------------|---|----------------|--|--|---|--------------------------|-----------------------------------|---|--|--|
| R | Physici /Medic | 27 | Decedent's Name (First, Middle, Last) DAISY Bell | ВА | ILEY | | 2. Date of Death Month FEB . 2 | 0 Day 2008 | 3. Time of Death 11:00 A M | |
| | Examin | الكوب رويفة | 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or | Location of Death | | 4c. County of Dear | th | |
| | | | COPPER RIDGE | | SYKES | | | CARROL | | |
| | Funeral Director | | 213-09-5412 ^{1□M 2} ♥F | yrs. last birthday) 3 Yrs. | If Under 1 Year Months Days | Hours Min. | 8. Date of Birth (Month, Day, | Year) 9. Bir Co /1914 MAF | thplace (State or Foreign ountry) RYLAND | |
| | aryland show d at | L | Usual Residence of Decedent 10a. State 10b. County 10c | c. City, Town or Lo | | | | | 10d. Inside City Limits 1 ☐ Yes 2 X No | |
| | Ba-f s | Director | MD CARROLL | FINKSBU | T | | | | | |
| | with the | Ë | 10e. Street and Number | | 10f. Zip Code | 0 | | og. Citizen of What Co USA | ountry? | |
| | eath is 23 | eral | 2125 BETHEL RD. 11. Marital Status 12. Was Decedent Ever | in U.S. 13 V | 21048 | | ecify Yes or No- | 14. Race - Ame | erican Indian. | |
| 36 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | by Funeral | Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: | | Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2【XNo | | Rican, etc.) | Black, Whit | | |
| 9 | 2 hou | pel | 15. Decedent's Education | 16a, Deced | dent's Usual Occupa | ation | | 16b. Kind of Business | b. Kind of Business/Industry | |
| 215 | hin 7; e. an "n Medi | ple | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) | (Give | kind of work done of DO NOT use retired | during most of work) | | | | |
| 7 | ed wit | Completed | 11 | | SEAMST | | | SEWING FA | ACTORY | |
| Maryland 21215-0036 | 2 should be filed and Mental Hygi is marked other aumatic event, t | Be | 17. Father's Name (First, Middle, Last) IRVIN | BELL | | 18. Mother's Name | | ŕ | | |
| $\frac{2}{3}$ | 2 should be and Mental is marked or aumatic eve | 2 | | | Add (Chart | | | ALENE NE | ESS | |
| <u>a</u> | d 2 sh th and 7 is n traun | | 19a. Informant's Name/Relationship (Type. Print) CHARLES D. HOLLMAN AUTODN | ļ. | • | | | | | |
| | Heal Heal tem 2 | | CHARLES D. HOLLMAN-ATTORN 20a. Method of Disposition | 20b. Place of Dispo | sition (Name of matory or other place | 1 51., W | | 20c. Location - City or | | |
| <u>o</u> E | Pages nent of h ant: if Ite ary or of | ľ | 1 M Bunal 2 Licremation 3 Li Hemoval from State | | natory or other plac IDGE CEM | 1 | /08 | PIKESVILI | E. MD | |
| Baltimore, | permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tra | | 21. Cign 1736 Furr ral Service Licensee | 22 | 2. Name and Addres | ss of Facility ${ m FL}$ | ETCHER | | HOME, P.A. | |
| | | | 23a. Parti. Enter the disease, or complications that caused the shock, or beart failure. List only one cause on at a line. | | | | | | Approximate | |
| | Physician | | Immediate Cause (Final | 1 | | - | | | Interval Between Onset and Death | |
| | /Medical | | disease or condition resulting in death) a | nsequence): | | | | | 4ears | |
| | Examiner | | | | | | | | | |
| | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | | | | | | |
| | ificate be executed g physician and as the burial-transit | Examiner | if any, leading to immediate cause. Enter Underlying Cause. Diversity in that initiated events resulting in death) Last Due to (or as a co | | | | | | | |
| 90, | be exi | Ē | Due to (or as a co | nsequence ot): | | | | | | |
| 68760, | cate t | edical | d | | | - | | | | |
| P.O. Box 6 | The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as | Physician/Me | in the pact 12 months? | If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 3□Ectopic pregnancy 4□Pregnant at time of death 5□ Other (specify) | | | | | elivery Day Year | |
| ds, P. | ires that t signed by i be detac | by | Part II. Other significant conditions contributing to death but no | ot resulting in the un | nderlying cause give | en in Part I. | 23e. Did tob | pacco use contribute t | o the cause of death? | |
| Ö | requ been should | etec | | | *************************************** | | 24a. Was a | | utanov findinga available | |
| Vital Records, | 2 as a | Completed | | | | | autops perforr 1 Yes | v prior to | utopsy findings available completion of cause of | |
| | siclan; Th certificate rector, pag | Be | 25. Was case referred to medical examiner? Hospital: Hospital: | | othe Othe | 26. Place of Deat | | | ASSISTED | |
| ō | Phys r this ral dii | -: T | 1 ☐ Yes 2 ☑ No Prospital 1 ☐ Inpatient 27. Manger of Death 28a. Date of Injury | 2 ER/Outpatien | IL S DOA | 4 LI Nursing Ho | | ence 6 X Other (Spenior injury occurred) | LIVING | |
| O | iding F th. : After s funera | tion | 1 ☑ Natural 5 ☐ Pending (Month, Ďay Ye 2 ☐ Accident investigation | ear) Injury | | k? Yes 2 □ No | | , | | |
| Division or | To the Hospital or Attending Physiclan: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page | Certification: | 3 Suicide 6 Could not be determined 28e. Place of injury building, etc. (5 | At home, farm, str Specify) | reet, factory, office | | 28f. Location (St City or Town | reet and Number or F n, State) | Pural Route Number, | |
| 9 | To the Hospital of within 24 hours af To the Funeral D completely filled it | edical C | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of manner: On the basis of examiner: On the basis of examiner stated | amination and/or in | | | | | | |
| | o the vithin o the omple | Med | 29b. Signature and title of certifier | | 29c. License | e number | 2 | 9d. Date signed (Mg/r | th, Day, Year) | |
| | ->-0 | | b little les mo | | Do | 05812 | ,7 | 2/200 | 8 | |
| , | | | 30. Name and address of person who completed cause of death | ı (Item 23a) (Type, | Print) | | | 1200 | 21157 | |
| | Sta | te_ | 31. Date filed (Month, Day, Year) 32. Registrar's | Signature Signature | 5+ 50 1 | West | winster | MO | 01171 | |
| | Regist | | FFR 2 1 2008 | K Asset | | | | | | |

| | | | For State | State of Mary | | partment of H ertificate of I | | | 2000 | 05210 |
|----------------------------|--|----------------|---|---|----------------------------------|--|--|--|--|--|
| | 8 | | Registrer 1. Decedent's Name (First, Middle, Last | et) | | | Journ | 2. Date of Death | | 3. Time of Death |
| | Physici /Medio | | Anna Kathryn | Baker | | | | Februar | y 18,2008 | 10:42 PM |
| | Examir | | 4a. Facility Name (If not institution, give Keswick Multi | | | | Location of Death | | 4c. County of Dea | |
| | Funeral | | 5. Social Security Number 6. S | | yrs. last birthd | ay) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | | hplece (State or Foreign |
| | Director | | 217-00-4303 | □M XXF | 92 Yrs | Months Days | Hours Min. | (Month, Day, 6-29-19 | 15 Mar | yland |
| | land w | | Usuel Residence of Decedent 10a. State 10b. County | 100 | c. City, Town or | Location | | | | 10d. Inside City Limits |
| | Mary | tor | Maryland N/A | | | Baltimon | æ | | | Mary 2 □ No |
| | or 28 | Director | 10e. Street and Number | | | 10f. Zip Code | 21211 | 10 | g. Citizen of What Co | ountry? USA |
| | eath w | | 711 W. 40th St | 12. Was Decedent Ever | in IIS 1 | 3 Was Decedent of H | | necify Yes or No- | 14. Race - Ame | |
| 21215-0036 | permit. Pages 1 and 2 should be illed within 72 hours after death with the Maryland Department of Heatth and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic avant, the Modical Exertine trains be notified at 000ce. | by Funeral | 1 □ Never Married 2 □ Married ★☆ Widowed 4 □ Divorced | Armed Forces? 1 ☐ Yes ★☑ No If Yes, Give Year or Dates: | | 3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2XXNo | Specify: | Rican, etc.) | Black, Whit | |
| 5 | "natu | Completed | 15. Decedent's Ed (Specify only highest gra | lucation de completed) | 16a. De | ecedent's Usual Occup- live kind of work done of e. DO NOT use retired | ation during most of work | king | 6b. Kind of Business | /Industry |
| 212 | y within | ошо | Elementary/Secondary (0-12) | College (1-4or 5+) | | Homemaker | , | | In own | home |
| | be filed tel Hyg d othe avent, | Be | 17. Father's Name (First, Middle, Last) | | | | | e (First, Middle, M | | |
| Maryland | Jould by Ment | P_C | Clinton Baubli | | 405.14 | allian Addana (Canada | | ie Finne | | Zin Code) |
| | Ath and 27 is r | | James L. Baker, S | _ | | ailing Address <i>(Street a</i> Elm Drive | | ore, Mar | | |
| altimore, | Pages 1 allent of Heanut: If Item | | 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify | Removal from State | cemetery (| sposition (Name of crematory or other place ne Park Cer | ا (م | | 00c. Location - City or Woodlawn, | |
| Balti | permit. Departm Importa | | 21. Signatur of uneral Service Licer | | - | 22. Name and Address Burgee-Hei 3631 Falls | nss-Seitz | Funeral | Home, Inc | and 21211 |
| | | | 23a. Part1. Enter the disease, or companies shock, or heart failure. List only | olications that caused the | death. Do not | | | | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | a. Ena-54 | | dementia | | | | I See and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as a co | nsequence of): | | | | | |
| | 7 - | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a co | nsequence of): | | | | | |
| | ficate be executed physicien end s the burial-transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | C. Due to (or as a co | Due to (or as a consequence of): | | | | | |
| 38760 , | sicien buria | alE | | 4 | | | | | | |
| _ | rtificate ng phy as the | Medical | 15 551.111 5 | . 0. | | | | | | |
| P.O. Box | The law requires that the death certificate has been signed by the ettending page 2 should be detached for use as i | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcome of pi 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown | Fetal death | 3 Ectopic pregnancy 5 Other (specify) | | | 23d. Date of de Month | livery Day Year |
| | w requires that the de been signed by the e should be detached t | b | Part II. Other significant conditions o | ontributing to death but no | ot resulting in th | e underlying cause giv | en in Part I, | | acco use contribute to s 2 ☑No 3 ☐ P | o the cause of death? |
| Division of Vital Records, | The law re ate hes bee page 2 sho | Completed | | | | | | 24a. Was ar autopsy perform 1 Yes 2 | prior to death? | utopsy findings available completion of cause of |
| Zita | Attanding Physician: r death. sctor: After this certifics by the funeral director, I | Be | 25. Was case referred to medical examiner? | Hospital: | | oth | or | th (Check only one | | |
| ō | y Phys er this eral dii | ٦. ٦ | 1 Yes 2 No 27. Manner of Death | 28a. Date of Injury | 28b. Tim | e of 28c. Injur | 41 Thursing Ho | ome 5 Reside 28d. Describe ho | nce 6 Other (Spe w injury occurred | ocify) |
| ion | ath. or: Afte | atio | 1 Matural 5 ☐ Pending 2 ☐ Accident investigation | | <i>ar)</i> Inju | | k? Yes 2 □No | | | |
| DIX | tal or Attu s after de al Directo ed in by ti | Certification; | 3 Suicide 6 Could not be determined | 28e. Ptace of Injury - building, etc. (S | At home, farm, pecify) | street, factory, office | | 28f. Location (Str City or Town | eet and Number or R , State) | ural Route Number, |
| | To the Hospital or Attanding Physician: The law within 24 hours after death. To tha Funaral Director: After this certificate hes completely filled in by the funeral director, page 2. | Medicai | 29a. Certifier (Check only one) 1 ★ Certifying Ph 2 ★ Medical Exam | ysician: To the best of miner: On the basis of exa and manner stated. | y knowledge, d mination and/o | eath occurred at the tin r investigation, in my o | ne, date and place, pinion, death occur | , and due to the ca rred at the time, da | use(s) and manner a ite and place, and du | s stated. e to the cause(s) |
| | with Tot com | Σ | 29b. Signature and title of certifier | Annau M | 1. \ | 29c. Licens | | 1 | d. Date signed (Mon | |
| , | 4 | | 30. Name and address of person who | | | D/3 | 55/ | H | bruary o | 0,2008 |
| 0 | 2 | | D. ISASELLE THE | SREGER, 70 | 10 W. 4 | OH STREE | IT, BALT | THERE, | 17) 2121 | <i>i</i> |
| 7 | Sta Registr | _ | 31. Date filed (Month, Day, Year) | 32. Registrar's | Signature | frage | | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2:40 p PHRIZELL BETHEA JR. FEB.17,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR CARE NURSING HOME TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) NOV.19,1928 S.CAROLINA 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 249 38 3659 79 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County X □Yes 2 □ No N/A BALTIMORE MD. Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2777 THE ALAMEDA 21218 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: BLACK ģ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9TH STATE SUPPLIES INVENTORY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be PHRIZELL BETHEA SR. HATTIE BERCH ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORRAINE BETHEA (wife) 2777 THE ALAMEDA BALTIMORE, MD. 21218 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) FEB 25,2008

GREEN MOUNT CREMATORY 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once, BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) re of Euneral Service Licenses $^{22,\,\text{Name and Address of Facility}}_{\text{CALVIN B. SCRUGGS FUNERAL HOME}}$ 1412 E . PRESTON ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ocardial Infarction Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due for as a consequence of **Examiner** Sequentially list conditions, it any leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 SNo 24a. Was an autopsy performe 1 Yes 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 5 Pending investigation 1 🌠 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 40054424 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cyrus Asadi, 20 E. Timenium od #209 Timenium, MD 21093 32. egistrar's Signatu 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 0 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** John Joseph Cardarelli 19, 2008 5:45 A February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Middle River 16 Slipstream Court Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Months XXM 2□F 81 1926 Maryland July 212-22-3406 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10b. County 1 ☐ Yes **XX**No Director Maryland Baltimore Middle River 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or be 21220 U.S.A. 16 Slipstream Court items 23a o permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Medical Examiner must by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 104 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Ness 2 No 1944-If Yes, Give Year or Dates: 1946 Black, White, etc. 1 □ Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dispatcher Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Cardarelli Leatha Davis ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16 Slipstream Court, Middle River, Maryland 21220 Mary Cardarelli - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem Garden 02/21/2008 Middle River, Maryland 4☐Donation 5☐Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Sig re of Funeral Service License 1407 Old Eastern Avenue, Essex, Maryland 21221 lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate
Interval Between
Onset and Death 23a. Part1. Inter the disease, or com shock, or heart failure. List only Immedia e Gruse (Final disease or Indition **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner OSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last sequence of Due to for as a c physician and stransit Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 DEctopic pregnancy Month ☐Yes 2☐No ed by the a 9∏Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an autopsy performe 2/ZXN0 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 ☐ Nursing Home SPAResidence 6 ☐ Other (Specify) 3□ DOA 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in McCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6+1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVOR UDX 31. Date filed (Month, Day, Year)

29c. License number

038635

29d. Date signed (Month, Day, Year)

32. Registrar's Signature

9600 NOLFTIMI.

(WLSAFO 10 2105

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifi

08-01307 Ricky Lee Coldiron

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1- For State Rea. No Registrar 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle,Last) Month Day February 15, 2008 Physician/ 0717 hrs Coldiron Medical Examiner Lee 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Worcester Ocean City 9400 Coastal Highway #1306 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 7. Age (in yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Maryland Months Days Hours April 17,1972 35 Director 217 17 8725 1 X M 2 F Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10h. County 10a. State Yes 2 X No 28a-f show Berlin Worcester MAryland death with the Maryland 10g. Citizen of What Country? 10f. Zip Code s 23a or 28a-f e notified at o 10e. Street and Number USA 21811 1162 Ocean Parkway 14. Race - American Indian, Black, Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Never Married 2 X Married Yes 2 X No White Yes 2X No specify: Specify If Yes, Give Yeer permit. Pages I and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o Divorced Widowed Ex miner <u>გ</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) other than " Condominium Maintenance Technician MD 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) O'Donnell Elaine Coldiron Be Robert. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19 Sorgen Court Middle River Maryland 21220 Dana Coldiron (wife) Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 2 X Cremation 3 Removal from State Baltimore, Maryland 02/20/2008 Bayview Crematory Inc Other Specify 22. Name and Address of Facility Bruzdzinski Funeral Home PA gnature of Funeral Service Licensee 1407 Old Eastern Avenue Essex Maryland 21221 nplications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval art I. Enter the disease, or co Between Onset and Physician liure. List only one cause q Death /Meidlica a Heroin Intoxication Immediate Cause (Final disease or sor dition resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical UNPENDED AMENDED attending physician or use as the burial -Box 68760, 23d. Date of deliver 23c. If yes, outcome of pregnancy IF FEMALE: Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown y the atte a Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. Yes 2 No 3 Probably 4 V Unknown ģ Completed 24b. Were autopsy findings available Division of Vital Records, 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 🗸 certificate director, page 26.Place of Death (Check only one) the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical æ Other₄ Nursing Home 5 Residence 6 Other: Scene examiner? Hospital: Inpatient 2 ER/Outpatient 3 this 1 Yes ၉ No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28b. Time of Injury After 27. Manner of Death Unknown Certification: FOUND: 1 Yes 2 ✔ No Natural Pending the Funeral Director: npletely filled in by the 0715 hrs Feb 15, 2008 Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) 9400 Coastal Highway #1306, Ocean City, MD Suicide determined (Specify) Multi-Family Apt. Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated ٥ 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie February 16, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner Registrar's Signature 31. Date filed (Month, State

Registrar

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2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician GORDON 1255 JOHN 02 18 20 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Bel Air Upper Chesapeake Medical Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex **Funeral** Months Days Hours 1 **2 1** P 78 Jan. 22, 1930 175-24-4762 Pennsylvania Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County Harford Bel Air 1 □ Yes 2 ₩o MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or USA ns 23a r 1002 Leeswood Road 21014 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Atmed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian 11 Marital Status Black, White, etc. r than "natural", or iten the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2**XX**Io Specify Specify: white þ 3 ☐ Widowed 4 ☐ Divorced or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Peach Bottom College (1-4or 5+) Elementary/Secondary (0-12) Power Plant Operator s 1 and 2 should be filed wi f Health and Mental Hygien tem 27 is marked other th 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Gordon John H. Casev 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 22 Walnut Drive-Kirkwood, Pennsylvania 17536 Department of Health a Important: If Item 27 is any Injury or other trains John Casey Jr—son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Evans Funeral Chapel Feb. 20, 2008 Forest Hill, Maryland Pages 1 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) And Cremations Belair 22. Name and Address of Facility
Fvans Funeral Chapel
And Cremation Services 3 Newport Drive Forest Hill, Maryland 21050 21. Signature of Funeral Service Licensee M 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: After this certificate has been signed by the attendin funeral director, page 2 should be detached for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. þ 1 ☐ Yes 2KÎNo 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1∐ Yes 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 No 1 Inpatient Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 € Natural 5 Pending investigation 1 TYes 2 TNo 2 Accident death. within 24 hours at er deaft To the Funeral Director 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 4 🗌 Homicide Hospital 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D56525 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BELAIR, MS VIOIL MAYS ST # (UL) 206 KHOSLA 31. Date filed (Month, Day, Year) FEB 2 1 32. Registrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 200 /Medical 4a. Facility Name (If not institution, give street and numbe 4c. County of Death **Examiner** Northwest Hospital Center Randallstown Harford if Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, July 12, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number . Age (In yrs. last birthday) **Funeral** Months Hours Days Min. Ĩ925 214-20-1466 82 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show at a or 28a-f shot be notified a 1 ☐ Yes 2 ☑ No VA Fauquier The Plains Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 3870 D Halfway Road 20198 USA r items 23a inner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married "natural", or 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. White þ 3 Widowed 4 □ Divorced Year or Dates: er than "natur , the Medical B Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, <u>Il once.</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Donald Gray Rita Bush ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3870 D Halfway Rd., The Plains, VA 20198 Douglas A. Coyner - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 2/14/08 Alexandria, VA 4 □ Donation 5 □ Other (Specify) P.O. Box 111 22. Name and Address of Facility 21. Signature Funeral Service Licensee Marshall, VA 20116 Royston Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Attended to Coron Coro Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, ightarrowphysician and s the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 2 No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? /es 2 2 40 certificate 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No 2 ER/Outpatient 3 □ DOA 1 ☐ Yes 1 Impatient Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 Alatural 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar NORTHWELT

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

dyve

31. Date filed (Menth Day, Year)

56430

401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 02 16 2008 13:30 Coleman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 💢 F Director 218-42-1904 65 02 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. sa or 28a-f show t be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Howard Columbia 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Items 23a 21044 5353 Harpers Farm Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, "natural", or Item: edical Examiner n Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed ♣☐ Divorced Black Completed ed other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Howard County Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 3yrs Communications General Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked or traumatic even Christine Manns James Stovall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health an
Important: if Item 27 is
any injury or other trau 10344 College Square, columbia, Md 21044 Monique Spears-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Woodlawn 2/23/08 Baltimore Co, 22. Name and Address of Facility 21. Signature of Funeral Service Licenses March F/H West ala 4300 Wabash Ave, Baltimore 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician exis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Exami resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the at d be detached for 4 Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No 1∏ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After 1. Natural 5 Pending investigation after death.

I Director: Af
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title/of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

32. Registrar's Signature

29c. License number

N. Charle St. Balto. Md 2120x

29d. Date signed (Month, Day, Year)

08-01447 Ch

| es Davis | | State of | Maryland / Depa <i>Cei</i> | | Health and | | | | 21 | 008 052 |
|--|-------------------|--|--|--|--|---|-------------------------|---|------------------------------------|---|
| Physicia cal Exami | ın/ | Registrar 1. Decedent's Name (First, Middle,Last) Charles H. Da | vis | | | | | ate of Death onth Da bruary 19, | | 3. Time of Death 1437 hrs |
| | , | 4a. Facility Name (if not institution, give st University Hospital | reet and number) | 4 | tb. City, Town, or Baltimore | Location of D | | | 4c. County of | |
| Funeral Director | | 5. Social Security Number 212-62-6813 6. Sex | 7, Age (In yrs. I | ast birthday) 55 Yrs | If Under 1 Yea Months Days | | 4Hrs. 8. I Min. | Date of Birth(N 2/17/ | 1953 | 9. Birthplace (State or Foreign Balt I More CountryMaryland |
| 5. We should be filled within 72 hours after death with the Maryland and 2 should be filled within 72 hours after death with the Maryland steadth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show any trammatic event, the Medical Examiner must be notified at once. | i Dire | Usual Residence of Decedent 10a. State 10b. County Maryland Baltimor 10e. Street and Number 7507 Clearlake La 11. Marital Status 1 Never Married 2 Married | e I | | | | | Yes or No- | White | States ica - American Indian, Black, , etc. |
| de filed within 72 hours after de denial Hygiene. narked other than "natural", or event, the Medical Examiner m | Completed by Fu | 15. Decedent's Education (Specify only Elementary/Secondary (0-12) | Dates: | 16a. Deceder during m | Yes 2 No nt's Usual Occupa ost of working life enance S | tion (Give kin DO NOT us upervi | e retired) SOL | | b. Kind of Bus Baltim Parks | |
| should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica | To Be Co | 17. Father's Name (First, Middle, Last) Joseph K. Da 19a. Informant's Name/Relationship (Type | 58130.03 | 19b. Mailin | g Address (Stre | E | leand | ot, Middle, Maid Or Fran Route Number | ces Wa | |
| permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er | | Patricia A. Bee 20a. Method of Disposition 1 | rs/ Sister Removal from State Ne | 403 Place of Dispose crematory or ote ew Cathe | Autumn sition (Name of ce her place) edral Ce | Harves metery, M. | t Cou ebrua 23, 2 | ert Ab | ingdon Oc. Location - Baltin | , Maryland City or Town, State ore, Maryland |
| hysician M Ji⊂al xaminer | | | ations that caused the death | n. Do not enter t | 232 | 2 JOLK | ROac | 1 TINO | III LUIII, | emation Ctr., I Maryland 21093 art Approximate Interva Between Onset and Death |
| executed ian and ial - transit | I Examiner | (Disease or injury that initiated C. | e to (or as a consequence of | | | | | | | |
| e death certificate be exe the attending physician a ed for use as the burial - | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | AMENDED 23c. If yes, outcome of pred Live birth Pregnant at time of d Unknown | 2 Feeath 5 O | etal death 3 ther (Specify) | | regnancy | | 23d. Date of Month | Day Year |
| law requires that th has been signed by 2 should be detach | Completed by P | Part II. Other significant conditions of | ontributing to death but not | resulting in the | underlying cause | given in Part | | | 2 No 3 | ibute to the cause of death? Probably 4 Vunknown Were autopsy findings availab prior to completion of cause of death? Yes 2 No |
| rs after death. In Director: After this certificate led in by the funeral director, page | To Be | 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation | 28a. Date of Injury Feb 11, 2008 | ER/Outpatien 28b. Time of 1757 hrs | t 3 DOA | Other Use of Death (Other | Nursing Ho | | | |
| To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the | al Certification: | 3 Suicide 6 Could not be determined 4 Homicide 29a Certifier 1 Certifying Physician | 28e. Place of Injury - At I (Specify) Major Roa t: To the best of my knowled | ad / Highway | y irred at the time, o | iate and place | Eas | or Town, Stat stern Avenue to the cause(s | e) @ Earls Ro s) and manner | er or Rural Route Number, Cit pad, Chase, Md. r as stated. |
| To the Hos within 24 h To the Fun completely | Medical | 29b. Signature and title of certifier | nd manner stated. | | 29c. Licen | n, death occu se number .M.E. | irred at the | 2 | | ned (Month, Day, Year) |
| y | tate trar | 31. Date filed (Month, Day, Year) | mbletied cause of death (Itel sistant Medical Exar 32. Registrar's Signa | niner 111 | Penn Street | , Baltimore | e, MD 21 | 1201 | | |

| | | | Please 1 | | | | | k. Ensure A | • | | 0 | |
|--------------------------------|--|------------------|--|--|---|-------------------------------|--|---|----------------------------|-----------------------|---|-----------------------------------|
| | | | For State | State of Ma | aryland | | artment of <i>rtificate o</i> | Health and I | Mental Hy | | | |
| | | | State Registrar 1. Decedent's Name (First, Middle, Last) |) | | | | Death | 2. Date of D | Reg. No | , 5 0 0 8 | 3. Time of Death |
| B | Physici /Medic | | Lucrecia J. Diaz | | | | | | Month Februar | y 15, | 2008 Year | 7:15 P M |
| P | Examin | ett. wa | 4a. Facility Name (If not institution, give | street and number) | | | 4b. City, Town | n, or Location of Death | 1 | | . County of Death | |
| | Funeral Director | | 215-15-3359 | TM 2DIF | e (In yrs. la | as <i>t birthday)</i> Yrs. | Silver If Under 1 Ye Months Day | ar If Under 24 Hrs. | 8. Date of Bi (Month, D | irth ay, Year, | Cou | place (State or Foreign intry) |
| | nd w | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | , Town or Lo | cation | | | | | 10d. Inside City Limits |
| | f short | ŏ | Maryland Prince Ge | eorges | | tsville | | | | | | 1 □Yes 2X□No |
| | the N 28a- | Director | 10e. Street and Number | | | | 10f. Zip Code | e | | 10g. Ci | tizen of What Cou | untry? |
| | 3a or | Ö | 8101 New Hampshire Ave | . Apt 5 | | | 20783 | | | Guat | emala | |
| 36 | be filed within 72 hours after death with the Maryland tial Hygliene. do other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent I Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give | | | | of Hispanic Origin? (Suban, Mexican, Puerl | | 10- | 14. Race - Amer Black, White Specify: Spa | |
| Ö | hour tural' al Ex | d be | 15. Decedent's Edu | Year or Dates: | T | 16a. Dece | dent's Usual Oc | cupation | | 16b. k | (ind of Business/l | |
| 5 | in 72 n "na Nedic | plet | (Specify only highest grade Elementary/Secondary (0-12) | | | (Give life. | kind of work do DO NOT use ret | ne during most of wor lired) | rking | | | , |
| 212 | d within giene. | Completed | 6 | College (1-40) 5 | T) | Homema | ker | | | 0 | wn Home | |
| land | should be filed nd Mental Hygin marked other imatic event, ti | To Be C | 17. Father's Name (<i>First, Middle, Last</i>) Felipe Ramos | | | | | 18. Mother's Nar Josefina | | le, Maidei | n Surname) | |
| ary | es 1 and 2 should b of Health and Ment fitem 27 Is marked or other traumatic e | - | 19a. Informant's Name/Relationship (T) | rpe. Print) | | 19b. Mailir | ng Address (Stre | eet and Number or Ri | ural Route Num | ber, City | or Town, State, Z | ip Code) |
| Σ | and 2 ealth n 27 I | | Leda Perez-daughter | | | 1021 | | ., #206, Gle | | | | |
| Baltimore, Maryland 21215-0036 | Pages 1 ment of H. ant; If iter ury or oth | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify, | | Ce | emetery, cřel | esition (Name of matory or other) Cemtery | place) ¦ | Date 19,2008 | 1 | el, Maryla | |
| Balt | permit. Page Department of Important; If any injury or once. | | 21. Signature of Funeral Service Licens | 01234 | | 1 | Fleck Fund | dress of Facility eral Home, I y Spring Rd. | NC . Laurel. | MD 2 | 0707 | |
| b | 200 | | 23a. Part1. Enter the di ease, or comp shock, or heart failure. List only of | lications that caused ne cause on each lir | the death | | | | | | | Approximate Interval Between |
| 題 | Physician | | Immediate Cause (Final disease or condition resulting in death) | Septic | | < | | | | | | Onset and Death |
| 17 | /Medical Examiner | | resulting in death) | Due to (or as | | | | | | | | |
| | LAAIIIIIICI | <u></u> | Sequentially list conditions, | b. Liver Due to (or as | | | | | | | | |
| / | nsit | Examine | Sequentially list conditions, if any, leading to immediate Cause (Disease or injury | | | lar Card | cinoma | | | | | |
| , | ficate be executed g physician and s the burial-transit | Exal | that initiated events resulting in death) Last | c Due to (or as | a consequ | ience of): | | | | | | |
| 68760, | te be ysicia ie bur | I — I | | d | | | | | | | | |
| 99 | rtifica ng ph as th | /ledi | IS SEMALE. | | - 50- | | | | | - 1 | | |
| .O. Box | The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit | Physician/Medica | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown | 2 Fetal | Ideath 3 | ⊒Ectopic pregna ⊒ Other (specify | | | | 23d. Date of deli Month | very Day Year |
| Δ. | that ned by deta | | Part II. Other significant conditions co | ntributing to death b | ut not resu | ılting in the u | nderlying cause | given in Part I. | 23e. Dic | d tobacco | use contribute to | the cause of death? |
| Records, | quires n sign uíd be | d by | | | | | | | 1 🗆 | Yes 2 | 2□No 3□Pr | obably 4 Unknown |
| 000 | aw requis been 2 shouf | Completed | | | | | | | 24a. Wa | as an topsy | 24b. Were au | topsy findings available |
| Ä | The lav | E | | | | | | | | rformed? | death? | |
| Vital | | Be C | 25. Was case referred to medical examiner? | | | | | 26. Place of De | ath (Check onl) | $\rightarrow \wedge$ | | • |
| or V | di S | To | 1 ☐ Yes 2X No | | | | II 3 DOA | | | | 6 ☐Other (Spe | cify) |
| n | ding Ph h. After th funeral | | 27. Manner of Death 1 Natural 5 ☐ Pending | 28a. Date of Inju (Month, Da | | 28b. Time o Injury | | njury at Work? | 28d. Describ | e how inj | ury occurred | |
| Division | or Atten ifter deat Director: in by the | Certification: | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of injusting, et | ury - At ho c. <i>(Sp</i> ec <i>if</i> y | ome, farm, st | | 1 Yes 2 No | | (Street a own, Sta | | ural Route Number, |
| | e Hospital 124 hours a le Funeral I | Medical C | | | f examina | | | ne time, date and place my opinion, death occ | | | | |
| | To the within 2 To the complex | Me | 29b. Signature and title of certifier | 2. | | | 29c. Lic | ense number | | 29d. D | ate signed (Mont | h, Day, Year) |
| | | | 1 N. 10 | | | | D6 | 5305 | | Feb | ruary 16, | 2008 |
| | J, | | 30. Name and address of person who o | | | | | | | • | | |
| | | | | Forest Gle | | | Spring, | MD 20910 | | | | |
| | Sta Regist | | 31. Date filed (Month, Day, Year) | 2. Registr | ars Signa | ture | A STATE OF THE STA | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 **Physician** hilip 0010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore of Maryland Medical Center Baltimore City If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F Days Hours 571-91-2099 25 Director 02-10-1983 Vietnam Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 1 ☐ Yes 2 X No must be notified Funeral Director MD Howard Elkridge 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 6495 Sedgewick Street 21075 United States Pages 1 and 2 should be filed within 72 hours after death items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 27 No f Yes, Give Year or Dates: 1 Never Married 2000 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Asian "natural" Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, the ones. 3 Owner/operator <u>Mailing Company</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jimmy Danh ပ Luong Ly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jimmy Danh - father 6495 Sedgewick Street, Elkridge, Maryland 21075 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐Removal from State Februar 4 □ Donation 5 □ Other (Specify) Catonsville, Maryland 23, 2008 Metro Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility Gary L. Kaufman Funeral Home at M00053 le H. Brilan MMP, Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** POXICL /Medical Due to r as a consequence of): Examiner acrest ardiac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed niliaen and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ brewn 1 Yes 2 No 3 Probably 4 Unknown Completed ernitently on pressors 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 1□ Yes 2.2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/2 No Inpatient 1 ☐ Yes ဥ 2 ER/Outpatient 3 DOA within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

Gore Marina 31. Date filed (Month, Day, Year) FEB 2 1 2008

29b. Signature and title of certifier



Buruna Gore MD Pley

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

MD#18146

29d. Date signed (Month. Day, Year)

21201

MD

| | | | State of Maryland / Department of Health a - For Certificate of Death | | | 7000 | 05220 |
|---------------------|---|----------------|--|-------------------------------------|------------------------|----------------------|---|
| | | | State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) | | Reg. Note of Death | No. | 3. Time of Death |
| | Physicia | an | _ | l N | Month D | Day Year 18 2008 | |
| | /Medic | _ | Mary Murray Dugan 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of | | | 4c. County of Dea | |
| t | Examin | er | 502 Old County Road Severna Park | | | Anne Aru | |
| | Functed | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 | 24 Hrs. 8. D | ate of Birth | 9. Bir | thplace (State or Foreign |
| | Funeral Director | | 077-30-1989 1 M 2 F 70 Yrs. Months Days Hours | Min. NC | Month, Day, Yea | 1937 New | ountry) York |
| | 7 | 1 | Usual Residence of Decedent | | | | 1404 1-14-00-11-1 |
| | irylan show | _ | 10a. State 10b. County 10c. City, Town or Location | | | | 10d. Inside City Limits 1XXYes 2 ☐ No |
| | e Ma Ba-f s | cto | MD Anne Arundel Severna Park | | - 1 | -11 | |
| | or 2 | Director | 10e. Street and Number 10f. Zip Code | | | Citizen of What Co | ountry? |
| | be filed within 72 hours after death with the Maryland Ital Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at | Funeral | 502 Old County Road 21146 | igin? (Specify | - 1 | 14. Race - Ame | erican Indian |
| | er de Item: ner n | in I | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 1 □ Yes 2 ∑ No 1 □ Never Married 1 □ Yes 2 ∑ No | n, Puerto Rica | n, etc.) | Black, Whi | |
| 36 | rs aft | by F | 3 ☐ Widowed 4 ☐ Divorced Year or Dates: | : | | Specify: | White |
| Ş | thon atura | be | 15 Decedent's Education 16a, Decedent's Usual Occupation | | 16b. | Kind of Business | /Industry |
| 15 | nin 72 n "ng Medila | plet | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most life. DO NOT use retired) | st of working | | | |
| 212 | d with giene ir tha the l | Completed | Grade 12 Homemaker | | | Own Home | |
| Maryland 21215-0036 | | Be C | - | , | st, Middle, Maid | len Surname) | |
| <u>a</u> | should be filed and that the filed was marked other umatic event, the | 2 | Michael Murray Ann | ne O'Re | e111A | | |
| al | 2 sho and I is ma | | 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number | | - " | | |
| | 라를 C I | | Thomas George Dugan / spouse 502 Old County Roa | | | | land 21146 |
| ore | 0 0 | | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place) | Date | ļ | . Location - City or | |
| altimore, | . Pag tment tant: jury | l l | 1.350.0000000000000000000000000000000000 | 2/22/20 | | urel, Ma | ryland |
| Ball | permit. Pag Department Important: I any Injury o | | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donal dson Funer 313 Talbott Ave | ^{ity} ral Hon enue I | ne, P.A. Laurel, | Maryland | 20707 |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. | | | | Approximate Interval Between |
| 0.5 | Physician | | Immediate Cause (Final disease or condition Multiplication Carre | u | | | Onset and Death |
| 0. | /Medical | | Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): | | | | |
| | Examiner | | Sequentially list conditions b. | er | | | |
| | p # | iner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | | |
| | ecute and -trans | Examiner | Cause (Disease or injury that initiated events resulting in death) Last C | | | | |
| 8760, | ficate be executed physician and s the burial-transit | | | | | | |
| 387 | physicate the | dical | d | | | | |
| × | leath certific attending p | /Me | IF FEMALE: 23c. If yes, outcome pf pregnancy | | | 23d. Date of de | elivery |
| ĕ | The law requires that the death certificate has been signed by the attending I bage 2 should be detached for use as | Physician/Me | 23b. Was decedent pregnant in the past 12 mg/fiths? 1 ☐ Yes 2 ☑ No 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) | | | Month | Day Year |
| o. | that the de led by the a detached f | ysi | 9 ☐ Unknown 9 ☐ Unknown | | | | |
| Records, P.O. Box | s that ned b | by PI | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | l. | 23e. Did tobaco | co use contribute | to the cause of death? |
| ĕ | w requires that s been signed I should be det | pe pe | | | 1 Yes | 2 No 3 F | Probably 4 ☐ Unknown |
| ပ္တ | aw re s bee | Completed | | | 24a. Was an autopsy | 24b. Were a | autopsy findings available completion of cause of |
| æ | The lav | E | | | performed 1 Yes 2 ☑ | death? | |
| Vita | | Be C | 25. Was case referred to medical examiner? | e of Death (CI | heck only one) | | |
| Ž | Physic this ce al dire | To I | 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nu | | | e 6 □Other (Sp | ecify) |
| o u | Attending Physician: r death. ector: After this certific by the funeral director, | | 27. Man of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? | | Describe how i | njury occurred | |
| <u>Si0</u> | tend leath. tor: / | cati | 2 Accident investigation M 1 Yes 2 3 | | Location (Stron | t and Number or F | Rural Route Number, |
| Division or | or Atlanta | Certification: | 4 Homicide determined building, etc. (Specify) | 201. | City or Town, S | tate) | ina riode italiaon |
| | Hospital 24 hours a Funeral etely filled | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date an | | | | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deal and manyer stated. | eath occurred a | at the time, date | and place, and di | ue to the cause(s) |
| | To the within ? | Me | 29b. Signature and title of certifier 29c. License number | 220 | 29d. | Date signed (Mor | nth, Day, Year) |
| | 7 | | Curty Harry MD 139 | 7708 | | 2/20 | 108 |
| j | 20 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | 940 | 1 | 201 | 1 - / |
| 0 | 70 | | Cuttes Harris mo 900 Bests ate Rd | 91030 | mua | 10/19 | M1) 21 40/ |
| | Sta | | 31. Date filed (Monty, Day, Year) 32 Registrar's Signature FFR 2 1 2008 | | | | |
| | Regist | ar | L'II W T TOO I WAS A STATE OF THE PARTY OF T | | | | |

DHMH 17 Rev 1/2001

State Registrar

74 KNOWIN

5:50 P M

9. Birthplace (State or Foreign

American

MD

Approximate Interval Between Onset and Death

years

Day

February 19, 2008

Year

10d. Inside City Limits

1 X Yes 2 No

1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 19, 2008 Anne Drew /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, 1)
Apr. 23, **Funeral** Year) 1942 Washington, DC Days Months Hours 1 □ M 2 🕶 F 65 579-54-6820 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10h County Director Washington, D.C. DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20012 USA 1600 Portal Drive NW Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. African 1 ☐ Yes 2 [2] If Yes, Give Year or Dates: 2 XNo 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify Specify. 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Instructor/Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Davenport Drew, Sr. Anne Lee Swanson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1600 Portal Drive NW Washington, D.C. 20012 Constance D. Drew/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory: 02/21/08 Beltsville, MD 21. Signature of Funeral Setvice Lices 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final End Stage Ischemic Cardiomyopathy disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Metastatic Breast Cancer 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 2 No 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 XNo 2 2 ER/Outpatient 3 □ DOA 1 X Inpatient 28b. Time of 27. Manner of Death Certification:

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

D37236

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

M.D. 6410 Rockledge Drive #506 Bethesda, MD 20817 Carolyn B. Hendricks,

31. Date filed (Month, Day, Year) State

32 Registrar's Signature

Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For Amend #7, perFH, 29d, perMD, 0876, 2/21/08 Tate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** SOPM 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner arrol asair MTAIR NUUSING Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Date of Birth (Month, Day, 6. Sex **Funeral** Months Days Hours Min. 1□ M 2□ 89 10-891 Maryland **Director** Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r 28a-f show notified at tyTyYes 2□No Directo Maryland Carroll Mt. Airy 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States of America "natural", or Items 23a or 4101 Old National Pike 21771 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes ZXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify Specify: White Completed by 3√Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) Hygiene. Garment 12th Seamstress marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 Estella Grace Fridinger P Allen L. Hann 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9 Kenosha, Wisconsin 53143 27 Gary L. Farver (Son) 8533 17th Avenue, other 1 If item 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or o MBurial 2 ☐ Cremation \3 □Removal from State Feb. 20, 4 Donation 5 Dother (Specify) New Lutheran Cemetery 2008 Man

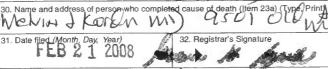
22 Name and Address of Facility
Eckhardt Funeral Chapel, P.A. Manchester, Maryland 21. Signature of Funeral 3 projecticense 3296 Charmil Drive, Manchester, Maryland 21102 23a. Pirtt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and or respira Immediate Cause (Final disease or condition resulting in death) Min no **Physician** arc /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examine requires that the death certificate be executed oenen the burial-tra Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part Records, Completed by ene horages 4 Unknown 2 🗌 No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ ▼ 0 24a Was an , page 2 s autopsy performed res 2 No has this certificate 1□ Yes or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 25 No 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P After thi funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 2 Accident Division Injury 5 Pending 1 🗌 Yes 2 No death. neral Director: A investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after d 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier 2/15/2008 Me

State Registrar

31. Date filed (Month, FEB 2 Day, Year) 1 2008

& Korken



NNA PC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 05224 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OSTA /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1 □ M 2 🗆 F Yrs. 216-44-5504 63 01-09-1945 **Director** MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" --- any ilury or other traumatic everance. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No Directo MD Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41 Daniel Drive 20711 by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: white 1 ☐ Yes 2 ☒ No Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Russell Yorks 2 Janice Gassaway 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Thomas Dean / husband 41 Daniel Drive; Lothian, MD 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Glen Haven Mem. Park | 02-23-2008 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee M00918 Services; 1 2nd Ave SW; Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) METASTATIC **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecuence of Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 D No Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the detached 9☐Unknown 9 Unknow signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 Unknown 2 No page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1 director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence Hospital: ĴΝο 1 Inpatient 1 ☐ Yes 2 □ EB/Outpatient 3 DOA P Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Natural 2 Accident 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760. To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After th

completely filled in by the funeral within 24 hours a

> State Registrar

29b. Signature and titl

32. Registrar's Signature

29c. License number D65635

(Hem 23a) (Type, Print) CY CONTAL SOOBES BATTE RD, ANNAPOUS MD 2440)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** FEBRUARY 14, 2008 1:00AM KIRKLAND D. DAVIS /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner RIVERDALE PRINCE GEORGES 5502 63RD AVENUE If Under 1 Year | If Under 24 Hrs. | 8 Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** XX M 2□ F Months Yrs 14, 1927 SOUTH CAROLINA Director 251 36 6519 Usuel Residence of Decedent 10d. Inside City Limits Pages 1 end 2 should be filed within 72 hours after death with the Marylend 10a. State 10b. County 10c. City, Town or Locetion or 28a-f show the Medical Examiner must be notified at XX Yes 2 □ No Director PRINCE GEORGES LANDOVER MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 1111 GONDAR AVENUE 20785 or items 23a Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? 11. Marital Status XXYes 2□No If Yes, Give Year or Dates: 1945-46 1 Never Married XX Married 1 ☐ Yes XX No Specify: Specify: BLACK Baltimore, Maryland 21215-0020 ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE (GILLETTE) LAB TECH 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be end Mental MARGARET WHITE CLARENCE DAVIS ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 67 or other tra RIVERDALE, MD 20737 5502 63RD AVENUE JEROME L. DAVIS / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition XX Burial 2 Cremation 3 Removal from State Department of Important: If any Injury or pace. MARYLAND VETERANS CEMETERY 2/27/08 CHELTENHAM, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Servica Licenses MARSHALL'S FUNERAL HOME OF MARYLAND, INC. K. 6 D. GRAY SUITLAND, MD 20746 4308 SUITLAND ROAD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a MALIGNANT NEOPLASM OF PANCREAS Examiner Due to (or as a consequence of) Examine icien end buriel-transit or Attanding Physician: The law requires thet the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. the attending physicien edical Due to (or as a consequence of) the Physician/M 23b. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2CXNo þ 8 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 2**X**XNo 1 ☐ Yes 2 ☐ No 1 ☐ Yes completely filled in by the funeral director, Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) SON'S Other: 4 Nursing Home 5 Residence XXIOther (Specify) RESIDENCE Hospital: 1 ☐ Inpatient 1 Yes XX No 2 ☐ ER/Outpatient 3 ☐ DOA ို After this 28c. Injury at Work? 28d. Describe how injury occurred . Manner of Death XX Natural 28b. Time of 28a. Date of Injury (Month, Day Year) Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funeral Director: Al 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide XX Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H (060005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9200 80 Leskus

Registra DHMH 16 Rev 6/95

State

31. Date filed (Month, Day, Ygar) 2008

Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 17, 2008 DORR EUGENE W. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Bayside Drive Pasadena 8167 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1**X** M 2□ F 75 20, 1932 Maryland 216-28-4953 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State "natural", or items 23a or 28a-f show adical Examiner must be notified at Director Anne Arundel Pasadena Maryland| 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 8167 Bayside Drive 21122 Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1XXVes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than " any injury or other traumatic event, the Mer Elementary/Secondary (0-12) College (1-4or 5+) U.S. Stee1 12 years Staff Representative 3 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Conaway William Dorr ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8167 Bayside Drive Pasadena, Maryland 21122 Patricia A. Dorr (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 KBurial 2 Cremation 3 Removal from State Meadowridge Mem. Park 2-20-2008 Elkridge, Maryland -5.☐ Other (Specify) Service Leonsee 21. Sign vivre of Funer McCully-Polyniak Funeral Home, P.A. J. Wayne Osterling 3204 Mountain Rd. Pasadena, MD 21122 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. MessTallaca Immediate Cause (Final disease or condition **Physician** /Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: yes, outcome pf pregnancy □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death in the past 12 months? 1 Yes 2 No 9 Unknown Month Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a, Was an autopsy performed? Yes No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 No Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Day

1:57 a^M

Birthplace (State or Foreign Country)

White

10d. Inside City Limits

1 ☐ Yes 2√ No

3404745

Year

4 Unknown

State Registrar

ည

Certification:

Medical

1 ☐ Yes

27. Manner of Death

1 Naturai

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

5 Pending investigation

6 Could not be determined

31. Date filed (Month, Day, Year)

FEB 2

29b. Signature and title of certifier

C40 Gorbul 32. Registrar's Signature 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Inpatient

(Month, Day Year)

28a. Date of Injury

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

40

28b. Time of

Injury

3□ DOA

28c. Injury at Work?

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

203 405 pital Drive Glea Burnie oup 20061

Other: 4 Nursing Home

1 ☐ Yes 2 ☐ No

027938

| | | • | 1 - For State Registrar | State of Maryland | | rtment of F tificate of | | | iene 00 { | 3 05227 |
|------------|--|-----------------|---|---|------------------------|--|---|--|----------------------|---|
| | | | 1. Decedent's Name (First, Middle, Last | | | | | 2. Date of Deat Month | h Day Ye | 3. Time of Death |
| | Physicia /Medic | | 156/2000 F | Ennis | | | | 2 | 13 0 | 0 |
| | Examin | | 4a. Facility Name (If not institution, give | | | | or Location of Death | | 4c. County of D | |
| | | | Fort Washington Ho | | at highday) | | shington | 9 Date of Birth | | George's Birthplace (State or Foreign |
| | Funeral | | 10 | T | 52 Yrs. | Months Days | Hours Min. | 8. Date of Birth (Month, Day, 10-24-19 | Year) | Country) shington, DC |
| | Director | | 220-62-5924 Usual Residence of Decedent | | 52 | | | 10 24 12 | ,55 114 | billing con, be |
| | yland | | 10a. State 10b. County | 10c. City | , Town or Loc | ation | | | | 10d. Inside City Limits |
| | Mar B-f st | ż | MD Prince Geo | orge's Fort | Washi | ngton | | | | 1. Yes 2 □ No |
| | or 28 | Director | 10e. Street and Number | | | 10f. Zip Code | | 1 | 0g. Citizen of What | : Country? |
| | within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show in Mardical Examinar must be notilliad at | | 13401 Cris Ran Co | | | 20744 | | | USA | |
| | tems | Funeral | 11. Marital Status | 12. Was Decedent Ever in U.S Armed Forces? | S. 13. V | Vas Decedent of I Yes, specify Cub | Hispanic Origin? (S an, Mexican, Puert | pecify Yes or No- o Rican, etc.) | | lmerican Indian, Vhite, etc. |
| 36 | s afte | by Fi | 1 Never Married 2 Married 3 Widowed 4 Divorced | 1 Tes 2 No | 1 | ☐ Yes 2🂢 No | Specify: | | Specify: B | lack |
| 21215-0036 | hour tural | | 15. Decedent's Edu | Year or Dates: | 16a Deced | ent's Usual Occu | pation | | 16b. Kind of Busine | |
| 5 | in 72 | Completed | (Specify only highest grad | le completed) | (Give I | rind of work done | during most of wor | kina | | ates Postal |
| 12 | iene. | E | Elementary/Secondary (0-12) 12th | College (1-4or 5+) | Clerk | | | 9 | Service | |
| b | be filed within 72 hours after death with the Marylan stal Hygiene. ed other than "natural", or litems 23e or 28e-f show event, the Madical Examiner must be notified at | 0 | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nar | ne (First, Middle, I | Maiden Surname) | |
| <u>a</u> | should be file and Mental Hy smarked oth | To B | Clarence Ennis | | | | | ine Snow | | |
| Maryland | ss 1 and 2 should be the alth and Ment them 27 is marked to other traumatic er | 1 | 19a. Informant's Name/Relationship (T) | | 19b. Mailin | g Address (Stree | and Number or Ru | ral Route Number | City or Town, Star | te, Zip Code) |
| | and 2 salth n 27 i | 1 8 | Debbie W. Ennis/Wi | | | | i Ct., Fo | | ngton, MD | |
| Baltimore, | of He | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I | Removal from State | metery, crem | sition (Name of natory or other pla | | | 20c. Location - City | |
| Ĕ | Pag ment ant: | | 4 Donation 5 □ Other (Specify, | Har | mony M | emorial | Park2-10 | -2008 | | Maryland |
| alt | permit. Pages 'Depertment of H Important: If Ite eny injury or of | | 21. Signature of Funeral Service Licens | | | | | | runeral nd, MD 20 | Home of MD |
| | 0 0 5 € Ø | | | CKUA | | | | | | Approximate |
| | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only of | ne cause on each line. | | | | | | Interval Between Onset and Death |
| 5 | Physician | | Immediate Cause (Final disease or condition resulting in death) | · Agreros | ile. | 1/2 / | secrt | Disec | se_ | |
| 1 | /Medical Examiner | | resulting in death) | Due to (or as a consequence) | ience of): | - | | | | |
| п | | _ | Sequentially list conditions, | b. Due to (or as a consequ | ence off: | .` ~ | | | | |
| | led nslt | nln | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | 550 (0 (0: 45 4 00:1004 | | | | | | |
| | xecu and al-tra | Examiner | that initiated events resulting in death) Last | c. Due to (or as a consequ | ience of): | | | | | |
| 8760, | icate be executed physicien and s the burial-transit | dical | | d | | | | | | |
| 687 | The law requires that the death certificate be executed ete has been signed by the ettending physicien and page 2 should be deteched for use es the burial-transit | ed | | · · | | | | | | |
| Вох | eath certific ettending p I for use es | by Physician/Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome of pregna | | IC-+: | | | 23d. Date of | |
| | death e ette d for | S | in the past 12 months? 1 □ Yes 2 □ No | 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de | | Ectopic pregnand Other (specify) | ;y | | Month | Day Year |
| 0 | trithe d by the teched | hys | 9 Unknown | 9□ Unknown | | | | | | |
| G, | res tha igned be del | oy P | Part II. Other significant conditions co | intributing to death but not resu | Ilting in the ur | nderlying cause g | iven in Part I. | | _ | te to the cause of death? |
| Records, | w require been sig | | | | | | | 1 🗆 Y | es 2□No 3[| Probably 4 Unknown |
| ပ္ပ | e law re hes be je 2 sho | ple | | | | | | 24a. Was a | sy prior | e autopsy findings available r to completion of cause of |
| | ysicien: The is certificate hi director, page | Completed | | | | | | perfor | med? deat | th? Yes 2□ No |
| ita | ilcien: Th certificate rector, pag | Be (| 25. Was case referred to medical examiner? | 2000 | | | | ath (Check only or | ne) | |
| of Vital | hysic his co | ုင္ | 1 ☐ Yes 2 No | - | ER/Outpatien | I 3LI DOA | | | ence 6 Other (| Specify) |
| ū | ing P | Ö | 27. Manner of Death Natural 5 Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | W | | 28d. Describe h | ow injury occurred | |
| Division | tend leath tor: / | Certification: | 2 Accident investigation 3 Suicide 6 Could not be | an Olympid Initial Alba | | |]Yes 2 □No | 20f Location /S | treat and Number | or Rural Route Number, |
| ĬŽ | or Al | E | 4 Homicide determined | 28e. Place of Injury - At he building, etc. (Specify | | eet, ractory, onice | 3 | City or Tow | | or ribrar ribble ribriber, |
| _ | To the Hospital or Attending Physicien: within 24 hours effer death. To the Funeral Director: Affer this certifical completely filled in by the funeral director. | | 29a. Certifier 1 Certifying Ph | ysicien: To the best of my kno | wiedne desti | accurred at the | ime date and place | e, and due to the | ause(s) and mann | er as stated. |
| | 24 ht Fun etely | edical | (Check only 2 Medical Exam | iner: On the basis of examina and manner stated. | tion and/or in | estigation, in my | opinion, death occ | urred at the time, | date and place, and | I due to the cause(s) |
| | vithin o the omple | Me | 29b. Signature and title of certifier | | | 29c. Licer | ise number | | 29d. Date signed (A | |
| | ->-0 | İ | 1 week | ali was | > | D005 | 4723 | | 2/13/ | 08 |
| | | | 30. Name and address of person who o | completed cause of death (Item | 23a) (Type, | Print) | | | | <u> </u> |
| | | | 11211 Constr | - ea F | | Surger | n n | D Dr | Pres | |
| | | ate | 31. Date filed (Month, Day, Year) | 32. Registrar's Signa | ture. | 25° A | | | | |
| | Regist | rar | FER 2 1 2008 | 10 A 10 A | | R. A. | | | | |

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item 15 per fb 2376 2-26-08 vt State of Maryland / Department of Health and Mental Hygiene 1 1 8

Certificate of Death 2. Date of Death 3. Time of Death **Physician** 2:20 P.M argaret Feb /Medical (If not institution 4b. City, Town, or Location of Death 4c. County of Death Examiner arkville If Under 24 Hrs. 8. Da BALTIMORE 7. Age (In yrs. last birthday)
Yrs. If Under 1 Year 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** Months 219-16-4592 Usual Residence of Decedent Days Hours Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show treumatic event, the Medical Examiner must be notified at BALTIMORE 1 ☐ Yes 2 No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 21234 10188 2326 USA or items 23e 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: β Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "neturei" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Hygiene. Elementary/Şecondary (0-12) Ker Department of Health and Mental Hygis Important: If item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Symame) ၉ vans eorae 19a; Informant's Name Velationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) MN 21234 Hanlon rkville Dale 20a. Method of Disposition 20c. Location - City or Town, State injury or 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Evans To reach a Chapet Bellfit 2 22. Name and Add ss of Facility ord 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Sevice Liverse any ir 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiador respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) neumonio Examiner Examine sician and rogressive supranucleur The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending physic Due to (or as a consequence of) ate has been signed by the a page 2 should be detached to Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate has 1 ☐ Yes 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Certification: To 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4UNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred eral Director: After filled in by the funer 5 Pending investigation 2 □ No after death. 1 Tes 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital
within 24 hours a
To the Funeral C Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of se 29c. License number P61785 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) d 8800 Walther Blud, Partville, MO 21234 Brosha 31. Date filed (Month, Day, Year) 3 Registrar's Signature

State

Registrar

FEB 2 1 2008

| | | | For State Registrar | State of M | aryland / | | artment of F | | nd Mental | Hygiei | / UU Ö | 05229 |
|----------------------------|---|-------------------------------|--|--|---|---------------------------|--|-------------------------|---|--|----------------------------|---|
| | Physici | | 1. Decedent's Name (First, Middle, La | Ann | Far | me | | | 2. Date Mon | of Death th | Day Year | 3. Time of Death /252 PM |
| | /Medio Examin | | 4a. Facility Name (If not institution, given by 77 Pars | on Aver | we | | 4b. City, Town, o | Inn (| Death | | 4c. County of De | ath Himone |
| | Funeral Director | | 5. Social Security Number 6. 5 | Sex 7. A(| ge (In yrs. last L | Yrs. | If Under 1 Year Months Days | If Under 2 Hours | | of Birth th, Day, Ye | | rthplace (State or Foreign Country) |
| | Maryland -f show iled at | tor | 10a. State 10b. County MD Baltim | ore | 10c. City, To | | | | | | | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No |
| | th with the 23a or 28a ist be noti | al Direc | 10e. Street and Number 6877 Parson | Avenue | | | 10f. Zip Code 21207 | · | | | Citizen of What C | Country? |
| 9036 | ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Heatth and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | Completed by Funeral Director | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Armed Forces' 1 Yes 21 If Yes, Give Year or Dates: | No | | Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No | an, Mexican, Specify: | gin? (Specify Yes , Puerto Rican, et | tc.) | Ame | ite, etc. Frican Prican |
| 21215-0036 | ed within 72 h giene. er than "natu i, the Medica | Complete | 15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 1 2 | ade completed) College (1-4or | 5+) | (Give life. | dent's Usual Occup kind of work done DO NOT use retired Sing Ai | during most d) de | | N | o. Kind of Busines ursing | |
| Maryland | 2 should be filed and Mental Hygi is marked other aumatic event, I | To Be | 17. Father's Name (First, Middle, Las Bruce Farme | r | | | | Rose | r's Name (First, Metta Fa | rmer | , | |
| , Mar | 1 and 2 sho Health and tem 27 is m | | 19a. Informant's Name/Relationship Michael Lawrer | | | 1350 | ng Address (Street | | ne, Boy | wie, | MD 207 | 20 |
| Baltimore, | permit. Pages 1 Department of H Important: If iter any injury or otl | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Control | (fy) | reme | tery, crei Zi c | osition (Name of matory or other place) on Cem | | /22/08 | La | ansdown | e, MD |
| Bal | permit Depar Impor any in | | 21. Signature of Funeral Service Lice | <u></u> | | | 2. Name and Address 126 Bela | | | | | |
| | Physician /Medical Examiner | _ | 23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, | a. Due to (or as | ine. Nod a consequence | e of): | | | mell with | - | | Approximate Interval Between Onset and Death |
| 8760, | cate be executed the burial-transit | lical Examiner | Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | C | s a consequenc | | | | | | | |
| P.O. Box 6 | The law requires that the death certificate has been signed by the attending page 2 should be detached for use as it | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown | | e pf pregnancy 2 ∐ Fetal dea at time of death | | □Ectopic pregnanc □ Other <i>(sp</i> ec <i>ify)</i> _ | у | | | 23d. Date of d Month | lelivery Day Year |
| | w requires that s been signed to should be deta | þ | Part II. Other significant conditions | | out not resulting | j in the u | inderlying cause giv | en in Part I. | 236 | e. Did tobac 1 | / | to the cause of death? Probably 4 □Unknown |
| II Reco | | Completed | | | | | | - | | a. Was an autopsy performed Yes 2 | death | autopsy findings available o completion of cause of ? es 2 No |
| Vita | Physician: Th r this certificate ral director, pag | Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 No | Hospital: | ient 2 ⊟ ER/0 | Outnatio | nt 3 DOA Oth | or: | of Death (Check | 1 | e 6 □Other (S _i | naoihi) |
| Division or Vital Records, | To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral d | Certification: To | 27. Magner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be | 28a. Date of Inj (Month, Date) | ury 28t | o. Time o | of 28c. Inju | | 28d. Des | scribe how | injury occurred | Rural Route Number, |
| Div | ospital or A hours after ineral Dire y filled in by | | | building, e | tc. (Specity) | lge, deat | th occurred at the t | | City | to the caus | State) se(s) and manner | as stated. |
| | To the Hospital within 24 hours a To the Funeral Completely filled | Medical | 29b. Signature and title of certifier | miner: On the basis and manner s | | anu/or ir | 29c. Licens | se number | | 29d. | . Date signed (Mo | onth, Day, Year) |
| | 5 | | 30. Name and address of person who | completed cause of | death (Item 23a | a) (Type, | Print) | 43881 | | | ornary 19 | γ, γνογ |
| | Sta | | Jason S. Javillo, MS 31. Date filed (Month, Day, Year) | | trar's Signature | | u, Baltin | erc, M | 0 21215 | | | |
| | Registi | ar | FEB 2 1 200 | and the same | 500 | A. 2 4 | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year February 19, 2008 **Physician** 2:25 A M Violet Edna Frey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Essex River View Care Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Days Min 1 □ M 2 🕅 F Yrs. Maryland 87 June 22,1920 218-01-2121 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show 1 ☐ Yes X☐ No Dundalk notified Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with "natural", or items 23a or 2504 McComas Avenue United States 21222 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. e filed within 72 hours after al Hygiene.

other than "natural", or ite 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Own Home Homemaker 8 Years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F Be be f Bertha Armstrong John Carback 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dundalk, Maryland 2504 McComas Ave. item 27 l Mr. Joseph F. Frey (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important; If it any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Gardens of Faith Cem. 2/21/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 21222 ine 23a, Part1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Est only one cause on each line. Immediate Cause (Final 12 Chamic **Physician** Kum disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Colonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) signed by the s d be detached t Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ tavence 2 No 3 Probably 4 ☐₩nknown Completed Severe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has certificate 1☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director, 26. Place of Death Check onl one Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division or Vital Records,

State Registrar M-D.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MALIKA WASBAM. 709. EAS 32. Registrar's Signature AND THE PARTY

ORIGINAL

TERN BLVD

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 MILDRED **Physician** FICO 2132 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis <u>Anne Arundel</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 20 F Yrs. Director 212-10-6196 15, 1919 Virginia Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f ehow other traumatic event, the Medical Exaculties at trust be notified at 1 Yes 2 No Director Maryland Anne Arundel Pasadena 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 8187 Orchard Point Road 21122 United States Funeral tams 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: by 3 Widowed 4 Divorced White natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Hathaway Furniture Co. 12 years n/a permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itsm 27 is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Merrie Belle Bucheit Lehman Hurley Norman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8187 Orchard Point Rd. Pasadena, MD 21122 Frank J. Fico, Sr. (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-21-2008 Carmel U.M. Cem. Pasadena. MD or Funeral s McCully-Polyniak Funeral Home, P.A. 3204 Mountain Rd. Pasadena, MD 21122 J. Wayne Osterling or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, at only one cause on each line. Approximate Interval Between Onset and Death Im rediate Cause (Final aspera mey morra Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ō Dav 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Department 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 DOA Director; After this in by the funeral d 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation after death. 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours a To the Funaral E Medical Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title 30. Name and address of I EYENSE HIGHWAY ANNABUS MOZIYOI ♠2. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 2 1 2008 Registrar

State of Maryland / Department of Health and Mental Hygieneo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 30, Henrietta Μ. Gibbons 2008 Year 11:52 PM January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carroll Home Care & Hospice Westminster Carrol1 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) New York Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🛛 F 90 1917 Director 063-10-0491 Dec. 4, Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County id 2 should be filed within 72 hours after death with the Marylan hand Mertal Hygiene. This marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits Director 1 ☐ Yes 2 X No Maryland Carroll Eldersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 2106 Harvest Farm Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Homemaker Own Home s 1 and 2 should be filed w Health and Mental Hygier tem 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Fox Henrietta Campbell ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Brian Gibbons (Son) 2106 Harvest Farm Rd., Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages ' 1 M Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Doyation 5 ☐ Other (Specify) 3 ☐Removal from State Calverton Nat. Cem. 2/4/08 Calverton, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Malverne Funeral Home Ulm 330 Hempstead Ave., Malverne, NY 11565 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Fibrosis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed attending physician and burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy ξ in the past 12 months? 1 ☐ Yes 2 K No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? res 2X No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice 1 ☐ Yes 2 📉 No ို 2 ER/Outpatient 3 DOA 1 | Inpatient After th funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 5 ☐ Pending investigation 1 Natural (Month, Day Year) 2 Accident 1 Yes 2 No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ulle Suff D20806 February 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Patrick Turnes, MD 1000 Liberty Rd., #102 Eldersburg, MD 21784 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB21 2008 Registrar

| | | For State Registrar | State of Marylan | | artment of F <i>rtificate of</i> | | | giene Reg. No. | 2008 | 05233 |
|---|---------------|--|---|------------------------|--|--|---|----------------------|---|---|
| Dharisis | | Decedent's Name (First, Middle, Las | 1) | | | | 2. Date of De Month | | Year | 3. Time of Death |
| Physicia /Medic | | MILDRED M. GROVE | € | | | | FEBRUA | | 8, 2008 | 6:00 P. ^M |
| Examin | er 🕆 | 4a. Facility Name (If not institution, give | street and number) | | 4b. City, Town, o | r Location of Deat | h | | County of Death | |
| Funeral Director | | 3207 FOXGLOVE LAI 5. Social Security Number 6. Se 217-18-0266 | | last birthday) Yrs. | MTDDLE If Under 1 Year Months Days | RTVFR If Under 24 Hrs Hours Min. | 8. Date of Birl (Month, Da 8/10/1 | h y, Year) | Cot | RE Inplace (State or Foreign Intry) RYLAND |
| and * | | Usual Residence of Decedent 10a. State 10b. County | 10c. Cit | y, Town or Lo | ocation | | | | | 10d. Inside City Limits |
| Maryl -f sho ied al | ō | MD BALTIM | ORF | MTDDL | E RIVER | | | | | 1 □Yes 2/□No |
| h the | Director | 10e. Street and Number | OILD | וטטטטוו | 10f. Zip Code | | | 10g. Citiz | zen of What Co | untry? |
| ath will | | 3207 FOXGLOVE LAN | E | | 21220 |) | | | SA | |
| In and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. The feath and Mental Hygiene and the filem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | | Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2√ No | lispanic Origin? (S an, Mexican, Puer Specify: | Specify Yes or No to Rican, etc.) | | 14. Race - Amer Black, White Specify: WH: | |
| //ithin 72 horner. han "naturie Medical E | Completed | 15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) | cation de completed) College (1-4or 5+) | (Give | dent's Usual Occup kind of work done DO NOT use retire | oation during most of wo d) | rking | | nd of Business/I | ndustry |
| Hygien Ther th | | 9TH GRADE 17. Father's Name (First, Middle, Last) | | HOI | MEMAKER | 18 Mother's Nar | me (First, Middle, | | | |
| d be f ental h ked of | To Be | CHARLES E. COOK | | | | | C. PFARF | | ourname | |
| 2 should be filed withing and Mental Hygiene. Is marked other than aumatic event, the M | ř. | 19a. Informant's Name/Relationship (7) | ype. Print) | 19b. Mailii | ng Address (Street | | | - | Town, State, Z | ip Code) |
| The and 2 Health a tem 27 is other tra | | DONNA HUDSON/DAUG | HTER | 344 | JACKSON S | TATION R | D. PERF | YVIL | LE, MD | 21903 |
| Pages 1 nent of He nt: If Iten | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ | Removal from State | cemetery, cre | osition (Name of matory or other pla | | Date | 20c. Lo | cation - City or | Town, State |
| t. Partmen rtant: | | 4 Donation 5 Dother (Specify | CHC | CEMET | LE VETER ERY | ANS 2/2 | 2/2008 | CRO | WNSVILL | E, MD |
| permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other | | 21. Signature of Funeral Service Ligen: | in Avisa | \sim $ \frac{1}{8}$ | 2. Name and Addre | RAVEN BI | HE JOHNS LVD. TO | ON FU WSON | JNERAL I , MD 2: | E, MD HOME, P.A. 1286 |
| Physician | | 23a, fart . Enter the disea . , or com shock, or heart failure. List only immediate Cause (Final disease or condition | cations that caused the deat ne cause on each line. | h. Do not en | ter the mode of dyin | ng, such as cardia | c or respiratory a | rrest, | 215g | Approximate Interval Between Onset and Death |
| /Medical Examiner | | resulting in death) Sequentially list conditions, | Due to (or as a conseq b. | uonoo of): | | | | * | | 14897 |
| ecuted and transit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | cDue to (or as a conseq | cuis | 5 | | | | | 1-20-08 3 ZANS |
| ate be hysicia the bur | edical E | L | Due to (or as a conseq | | | | | | | 3 RANS |
| , <u>*=</u> | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 profiths? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome pf pregna 1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown | Ideath 3 | □Ectopic pregnanc □ Other (specify) _ | / | | 2 | 3d. Date of deli Month | very Day Year |
| quires that n signed build be deta | ρ | Part II. Other significant conditions or | ontributing to death but not res | ulting in the u | nderlying cause giv | en in Part I. | 23e. Did t | | | the cause of death? obabiy 4 ☐Unknown |
| | Completed | | | | | | 24a. Was autop perfo 1□ Yes | | 24b. Were au prior to death? 1 ☐ Yes | topsy findings available completion of cause of |
| sician: T certificat rector, pa | Be (| 25. Was case referred to medical examiner? | I I a a Male | | 100 | | ath (Check only o | ne) | | |
| Physi this c | 2 | 1 Yes 2 17 No | Hospital: 1 ☐ Inpatient 2 ☐ | ER/Outpatier | | 4 🗆 Nursing F | dome 5 Resident | | | cify) |
| ding h. After funer | tion | 1 ✓ Matural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Year) | Injury | Wor | k? Yes 2∐No | zou. Describe | iow injury | y occurred | |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director. | Certification | 3 Suicide 4 Homicide 6 Could not be determined | 28e. Place of injury - At he building, etc. (Specif | ome, farm, sti (y) | reet, factory, office | | 28f. Location (3 City or Tox | | | ral Route Number, |
| ne Hospit n 24 hours ne Funera | edical (| 29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exam | vsician: To the best of my kno iner: On the basis of examina and manner stated. | wledge, deat | h occurred at the ti | me, date and place opinion, death occ | e, and due to the urred at the time, | cause(s) date and | and manner as place, and due | stated. to the cause(s) |
| To th withir To th | Me | 29b. Signature and title of certifier | st. Cami | ch | 29c. Licens | e number | | | e signed (Mont) | |
| 37 | - | 30. Name and address of person who o | | | | | | | | |
| | | Francis Carmody, N | | | Suite | 212 Tows | son, MD | | | |
| Stat | | 31. Date filed (Month Day, Year) 20 | 08 32 Registrar's Signa | 5 | sign | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 2008 Month **Physician** -WPM PURDY HANNAFORD 20 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE LOCH ROVES HEALTH CARE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2**V**F Days 223-07-8162 94 09 1914 VIRGINIA **Director** Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No "natural", or items 23a or 28a-f st edical Examiner must be notified BALTIMORE BALTIMORE Director MD 10g. Citizen of What Country? CHARLES ST. USA 21201 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0038 Specify: Specify: WHITE If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) LIFE INSURANCE SECRETARY 12 other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NELLIF SMITH CHARLES RICHARD PURDY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 1846 FOLEWOOD RD. BALTIMORE, MD 21234 DAWN KUNE/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If It any Injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 18/2008 HANDULR, MD 4 Donation 5 ☐ Other (Specify) ANATOMY GIFTS NEGISTRY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DWATONY GIPTS DELISTRY 7533 CONNELLEY DR. HANDUIR MD 31076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or se a consequence of): Hourt Failure Examiner 25 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine -transit and Due to (or as a consequence of): physician a the burial-t Box 68760, Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? for Month Day Year 5 ☐ Other (specify) P.O. 1 the detached 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 ☐ Probably 4 🛣 Ûnknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2√ No 24a. Was an has page 2 autopsy performed 1□ Yes 🎾 certificate **2**€ No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Other: 45 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2**X** No 3□ DOA မှ 1 Inpatient 2 ER/Outpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: or Attending 1 X Natural 5 Pending Injury 1 ☐ Yes 2 □ No death. investigation 2 ☐ Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certifier 29c. License number 4202 0 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

| | 1 - For State Regi |
|------------|------------------------------|
| ian cal | 1. Decede |
| ner | 4a. Facilit |
| | 5. Social 220 |
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Physician /Medical Examine

Funeral Director

| | FIE | | | | | | | | | | | | e Legi | Die. | |
|--|---------------------------------|---------------------|-----------------------|--------------------------|---------------------------------|-------------------------------|------------------|---------------------------------|------------------------|-------------------------|----------------------------|--|-------------------------|---------------------------------------|---|
| For State Registrar | | | State o | or Ma | ryiand | l / Depa | | nt of F | | | Vienta | Hygie Reg. | -711 | 80 | 05235 |
| 1. Decedent's Name Cathe | erine | | Hord | | | | | | | | 2. Date Feb | of Death th 20 | Day 200 |) Š ^{ear} | 3. Time of Death 4: 24A M |
| 4a. Facility Name (It | | - | | | | | 4b. Cit | y, Town, o | | of Death | ı | | 4c. County | | |
| | /irgi | | Aven | - | | | 1611- | Ess | | o = 0.4 Lluo | | | F | | imore |
| 5. Social Security N 220-14- | -0540 | 6. Sex 1□ | M 2 ∏ F | 7. Age | (In yrs. la | st birthday) Yrs. | Month | er 1 Year s Days | Hours | er 24 Hrs. Min. | Apr | of Birth th, Pay, Ye | 8,19 | 9. Birt 21 Co | hplace (State or Foreign untry) MD |
| Usual Residence of 10a. State | 10b. County | , | | T | 10c. City, | Town or Lo | cation | | | | | | | | 10d. Inside City Limits |
| MD | Balt | imo | re | | | E | sse | K | | | | | | | 1 ∐Yes 2XX No |
| 10e. Street and Nur 706 V | mber /irgin | nia | Aven | ue | | | 10f. 2 | Zip Code 212 | 21 | | | 10g. | USA | What Co | ountry? |
| 11. Marital Status | | 1 | 2. Was Dec Armed F | cedent Ev | ver in U.S | 13. | Was Ded | edent of F | lispanic C | origin? (S | pecify Yes to Rican, e | or No- | | e - Ame | rican Indian, |
| 1 □ Never Marri 3 🏲 Widowed | | | | 2 □X No ive | 0 | | | 2[X No | Specif | | | , | | | nite |
| (Spec | 15. Deceder | nt's Educ | ation completed |) | | 16a. Dece | dent's Us | sual Occup | ation | ost of wor | rkina | 16 | b. Kind of B | usiness/ | Industry |
| Elementary/Seco | | J. Grade | College | |) | Ho: | mema | vork done use retire aker | d) | 00. 01 1101 | Ming | | own | hom | ne . |
| 17. Father's Name (| | | | | | | | | | | , . | Middle, Mai | iden Surnan eun | ne) | |
| 19a. Informant's Na | | | | augl | nter | | - | | and Num | ber or Ru | ıral Route | Number, C | ity or Town, | | Zip Code) 21221 |
| 20a. Method of Disp | | | , a | augi | 20b. Pla | ace of Dispo | sition (A | lame of | 1 | | Date | | | | Town, State |
| P☐ Burial 2 [4☐Doration | ☐ Cremation | | emoval from | State | Mor | elan | matory o d Me | r other pla emor | ľal | 2/2 | 3/08 | | altim | | |
| 21. Signature of Fu | ineral Service | License | Po, | 1.0 | | 1 | | and Addre | | 31 | | | | | to. MD |
| 23a. Part1. Enter the shock, or hea | he disease, o | r complic | ations that | cause / | e death. | | | | | | | | | 1 | Approximate Interval Between |
| Immediate Cause (disease or condition resulting in death) | Final | a. | | Ko | FN | MT L | 1 | FA | II | -V1 | ZE | | | | Onset and Death |
| | | | Due to | (or as a | conseque | ence ot): | | | | | | | | | • |
| Sequentially list con if any, leading to im cause. Enter Unde Cause (Disease or | nditions, nmediate rlying | Į b. | Due to | (or as a | conseque | ence of): | | | | | | | | | |
| that initiated events resulting in death) L | 3 | c. | Due to | (or as a | conseque | ence of): | | | | | | | | | |
| | | L _d . | | ` | | | | | | | | | | | |
| IF FEMALE: | | | | | | | | | | | | | | | - |
| 23b. Was decedent in the past 12 1 Yes 2 5 9 Unknown | months? | 23 | | birth 2 nant at t | f pregnan Petal ime of de | death 3 | | pregnanc (specify) _ | У | | | | | te of del onth | livery Day Year |
| Part II. Other signif | | ions cont | tributing to | death but | not resul | ting in the u | nderlying | g cause giv | en in Par | t I. | 236 | e. Did tobac | co use con | tribute to | the cause of death? |
| | jab | ete | 25 | | | | | | | | | 1 🗌 Yes | 2 No | 3 □ Pr | robably 4 □Unknown |
| | tear | 1 | 01 | SCO | 12 | | (07 | NN | an | 1 | | . Was an autopsy performe Yes 2 | 92 | Were au prior to death? 1 □ Yes | utopsy findings available completion of cause of 2 No |
| 25. Was case refer examiner? | red to medica | | | | | | | | 26. Pla | ce of Dea | ath (Check | only one | | | |
| 1 Yes 2 1 | | H | | | | R/Outpatie | | | 4 🗆 1 | Nursing H | forme 5 | Residenc | e 6 🗆 Oth | ner (Spe | cify) |
| 27. Manner of Death 1 ☐ Natural 2 ☐ Accident | 5 🗌 Pendi | ng igation | 28a. Date (Mo. | of Injury nth, Day | | 28b. Time o Injury | f M | 28c. Injui Woi 1 🗆 | ryat k? Yes 2[| □No | 28d. Des | scribe how | injury occur | red | |
| 3 ☐ Suicide 4 ☐ Homicide | 6 ☐ Could detern | | 28e. Plac build | e of injur ding, etc. | y - At hor (Specify) | ne, farm, st | reet, fact | ory, office | | | 28f. Loca City | ation (Stree or Town, S | et and Numl State) | per or Ri | ural Route Number, |
| 29a. Certifier (Check only one) | 1 Certifyi 2 Medica | ng Phys i Examin | er: On the | e best of basis of e | examinati | vledge, deat ion and/or in | h occurr | ed at the ti | me, date opinion, d | and place leath occi | e, and due urred at the | to the cause time, date | se(s) and me and place, | anner as | s stated. e to the cause(s) |
| 29b. Signature and | title of certific | r Pr | | | | | 2 | 29c. Licens | e numbe | г | | 29d | . Date signe | d (Mont | h, Day, Year) |
| > | 18 | | | | MD | | | D | 52 | 379 | Ì | | 2 | 20 | 108 |
| 30. Name and addr | | | npleted cau | | | 23a) (Type, | | \sim | 0 6 | A | · B | n li | imin | 11 | 40 21 221 |

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

31. Date filed (Month, Day, Year) 2008

32 Registrar's Signatore

| 08-01338 | |
|-----------|--------|
| Georgeona | Harvoy |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 05236

| | | 1- For State Registrar | | Certifi | icate of | Death | | | | ı | Reg. No. | | | |
|--|----------------|--|---|-----------------|-----------------|----------------|---------|-------------|--------------|---|--------------|-------------|--------------|---|
| Physicia | an/ | 1. Decedent's Name (First, Middle,L | ast) | | | | | | | . Date of De | ath | | | 3. Time of Death |
| ledical Exami | ner | Georgeena Ha | rvey | | | | | | | Month February | 16, 20 | Year | ٢ | 0740 hrs |
| | | 4a. Facility Name (if not institution, g | ive street and number) | | 41 | . City, Towr | , or Lo | cation of | | ······································ | | . County of | f Death | |
| | | Maryland General Hospi | al | | | Baltimor | е | | | | | N/A | 7 | |
| Funeral | | Social Security Number 6. | Sex 7. Age | (In yrs. last b | birthday) | If Under 1 | Year | If Under | 24Hrs. | 8. Date of E | 3irth (MM/ | DD/YYYY) | g. Birth | nplace (State or |
| Director | | 213-64-5715 | | 50 | | Months | Days | Hours | Min. | 6/18 | | | Enroise | |
| | | | M 2 X F | 50 | Yrs. | | | | | | | | Coul | ntry) 222 |
| any | | Usual Residence of Decedent 10a. State 10b. County | | Inc City Toy | wn or Locatio | n | | | | | | | | 10d. Inside City Limits |
| * . | | MD N/A | | | timor | | | | | | | | | 1 X Yes 2 No |
| Maryland 28a-f show d at once. | ō | | | | | | | | | | | | | |
| Mary 28a- d at | Director | 10e. Street and Number | | | | 10f. Zip Coo | | | | | - | zen of Wha | at Count | iry? |
| th the Maryland 23a or 28a-f sho | | 126 S. Mount | St. | | | 212 | 23 | | | | U | SA | | |
| with ms 2. | Funeral | 11. Marital Status | 12. Was Decedent B | ver in U.S. | | | | | | ify Yes or N | 10- | | | an Indian, Black, |
| death r ite | ű | 1 Never Married 2 X Marrie | Armed Forces? | X No | If Ye | s, specify C | ıban, M | Mexican, F | Puerto R | ican, etc.) | | White, | ric. | an |
| ifter of large of lar | by F | 3 Widowed 4 Divorce | ed If Yes, Give Year | X. NO | 1 ' | Yes 2 X | No s | specify: | | | | | | rican |
| ours a | | 15. Decedent's Education (Specify | only highest grade comp | oleted) 16 | a. Decedent' | | | | | | | Kind of Bus | | |
| 72 ho | ompleted | Elementary/Secondary (0-12) | College (1-4 or 5- | +) | | st of working | life. D | O NOT u | se retire | d) | 1 | D = ** | | |
| 336 thin thin than | Idu | 8 | | | M | laid | | | | | | Bar | | |
| 5-0 sd wi lygie of the | S | 17. Father's Name (First, Middle, La | st) | | | | 18. | .Mother's | Name (F | First, Middle | , Maiden | Surname) | | |
| 215-0036 be filed within 7 nual Hygiene. rked other than | Be | George Alston | | | | | G | ret: | rude | e Bar | ber | | | |
| Men Men c eve | P C | 19a. Informant's Name/Relationship | | Ţ. | 19b. Mailing | Address (S | treet a | nd Numb | er or Ru | ral Route Nu | umber, Ci | ity or Towr | n, State, | Zip Code) |
| MD d 2 shc Ith and n 27 is aumati | | Ladonia Tyler | /daughter | 24 | 126 S | . Mo | unt | st | ., I | Balt. | , M | D 2 | 122 | |
| imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f short other traumatic event, the Medical Examiner must be notified at once | | 20a. Method of Disposition | | | e of Disposit | | f ceme | tery, | | Date | 20c. i | Location - | City or T | Town, State |
| ges l t of l | | 1 X Burial 2 Cremation 3 | Removal from Stat | ~ <u> </u> | natory or othe | | | | 2/25 | 5/08 | La | nsdo | wne | , MD |
| altimore, mit. Pages I ar partanent of Hec portant: If ite | | 4 Donation 5 Other Speci | | Mt. | Zion | | | | | | | | | |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 77 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical | | 21. Signature of Funeral Pervice U | nsee 0 & | 2 | 22. Na | me and Add | ress of | f Facility | Har: | į P. | Clo | se_F | 205 | vs,PA |
| | _ | 23- B-41 F-44 | | | 512 | 6 ве | Laı | rRe | a, 1 | sait. | , MI | 0 21 | 206 | |
| Physician /Medical | | 23a. Part I. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | | | irt | Approximate Interval Between Onset and |
| xaminer | | Immediate Cause (Final disease | Immediate Cause (Final disease a. Complications of cocaine and narcotic use & diabetes mellitus | | | | | | | | | | | Death |
| | | or condition resulting in death) | Due to (or as a consec | quence of): | | | | | | | | | | |
| | _ | Sequentially list conditions, | D | | | | | | | | | | | |
| | اقِ | if any, leading to immediate cause. Enter Underlying Cause | Due to (or as a consec | quence or): | | | | | | | | | | |
| _ | Examiner | (Disease or injury that initiated events resulting in death) Last | Due to (or as a consec | quence of): | | | | | | | | | | |
| cuted ind transit | | | d | | | | | | | | | | | |
| 760, cate be execut physician and he burial - tra | sician/Medical | XUNPENDED | AMENDED #23a,27,per | MT - 000 | 6/5/00 | . mm | | | | | | | | |
| 8760, tificate being physicias the buri | ě | IF FEMALE: | 23c. If yes, outcome | of pregnan | 0/3/08 cv | 11 | | | | | 230 | d. Date of | delivery | |
| 687 sertific iding p | au/ | 23b. Was decedent pregnant in the past 12 months? | 1 Live birth | | 2 Feta | il death | 3 | Ectopic | pregnand | у | | Month | | ay Year |
| Box 687 e death certific the attending of for use as the | <u> </u> | 1 Yes 2 No 9 ✔ Unknow | 4 Pregnant at t | | | er (Specify) | | | | | | | | |
| e de fe | Phys | | 9OHKHOWH | | | _ | | | _ | | | | | |
| ires that the signed by the detach | b P | Part II. Other significant conditions | contributing to death | but not result | ting in the un | derlying cau | se give | en in Part | t I. | | | | | he cause of death? |
| ires t | 힣 | | | | | | | | | 1Y | es 2 ✓ | No 3 | Proba | ably 4 Unknown |
| ords, w requir s been s should b | Completed | | | | | | | | | 24a. Wa | s an opsy | | | opsy findings available ompletion of cause of |
| e ław e has ge 2 s | Ę | | · · · · · · · · · · · · · · · · · · · | | | | | | | per | formed? | d | leath? | |
| tal Rec | | 25. Was case referred to medical | | | | 20.5 | | Dooth / | Ob a ale a a | 1 Yes | 2 N | 0 1 | ✓ Yes | s 2 No |
| ician ician s cert recto | å | examiner? | Hospital: 1 Inpatien | | /Outpatient | | | f Death (C | | | 55 | | 700 | |
| of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should | ို | 1 Yes 2 No 27. Manner of Death | | | b. Time of Inj | | L | at Work? | | Home 5 8d. Describe | | ence 6 | Other: | |
| n of ding Pl h. After funera | Certification: | 1V Natural | 28a. Date of Injury (Month, Day,Ye | ar) | o. Time of m | · 1 | | s 2 1 | - 1 | ou. Describe | s now inju | ny occurre | sa | |
| Sio Vitten deatl cror: | Ę | 2 Accident Pending | | | | | | | | | | | | |
| Division tal or Attendir rs after death. at Director: A | ١ | 3 Suicide 6 Could no | | ry - At home | , farm, street | , factory, off | ce buil | lding, etc. | 2 | 8f. Location or Town, | | nd Numbe | er or Rur | al Route Number, City |
| Spita nours neral | Ö | 4 Homicide determin | ed (Specify) | | | | | | | _ | | | | |
| e Ho 1241 e Fu | g | | cian: To the best of my | _ | | | | | | | | | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the funeral director. | Medical | | er:On the basis of exam and manner stated. | ination and/o | or investigatio | | | | urred at t | ne time, dat | | | | |
| | Σ | 29b. Signature and title of certifier | 1 | | | 29c. Lic | ense n | number | | - | 29d. I | Date signe | ed (Mon | th, Day, Year) |
| | | Mourine Dr | e Uhile | | | 0 | .C.M. | Ε. | | | Feb | ruary 17 | 7, 200 | 8 |
| | | 30. Name and address of person who | completed cause of de | ath (Item 23a | 3) | | | | | _ | | | | |
| 1 | | Margarita Korell MD. A | ssistant Medical E | xaminer | 111 Pe | nn Street | , Balt | timore, | MD 21 | 1201 | | | | |
| St | ate | 31. Date filed (Month, Day, Year) | \$2. Registrar's | Signature | 9 - 25 | | | | | | | | | |
| Regist | rar | FFB 2 1 200 | 8 | 136 A | and I | 7 | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien® 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 7,2008 February 1614 Reginald Oswald Hackley /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner Prince Georges Hospital Prince Georges Center Cheverly If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) Hours Months Days 1**X** M 2□ F Yrs Director 226-54-0754 March 23, 1942 Virginia 65 Usual Residence of Decedent Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov the Medical Examiner must be notified at Upper Marlboro 1**X** Yes 2 □ No MD Prince Georges Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 10119 Prince Place 20774 USA itema 23a Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian. Black, White, etc. iled within 72 hours after 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Pvt. 12 Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Mattie Hackley Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: if itam 27 is any injury or other tree Pages 1 and 2 Denise Hackley/Wife 10119 Prince Place, Upper Marlboro, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Riverdale Crematory2/18/08 4 □ Donation 5 □ Other (Specify) Riverdale, MD 22. Name and Address of Facility Austin ROyster Funeral Home 21. Signature of Funeral Sen 3821 14th Street, N.W., Washington, DC20011 Approximate Interval Between Onset and Death 29a. Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Peripheral Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospitei or Attending Physician: The law requires that the death certificate be executed LOYCUTC Y resulting in death) Last Due to (or as a consequence of) ding physician Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? a No ZO No 1 ☐ Yes 1 🗌 Yes After this certification, I 25. Was case referred to medical Be 26. Place of Death [Check only one] Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No atient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending death. 1 TYes 2 No investigation 2 Accident Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Direct 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 021081

State Registrar

21 DHMH 17 Rev 1/2001

Tohammac

31. Date filed (Month, Day, Year)

hummad. Sari-arazi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Sar i-arazi

32. Registrar's Signature

valerian lane 13 ockulle

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** February 19, 2008 9:20 PM /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Fecility Neme (If not institution, give street end number) Examiner Kline Hospice House Frederick Mt. Airy If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Deys Hours Months 1 □ M 2 🛛 F Yrs. Director 89 212-16-6230 5, 1918 Maryland Sept Usuel Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Completed by Funeral Director MD Frederick <u>Monrovia</u> 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4210 Lynn Burke Road 21770 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1□ Yes 2√2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 Secretary <u>Education</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Lest) Be Robert Lee Burkett Martha Ellen Knup 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Linda Meyer/daughter 4803 Lynn Crest Ct. Monrovia, MD 21770 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6 Injury Chesapeake Crematory 2/21/08 Beltsville, MD 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 21. Signature of Funerat Servica Licansee MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD21029 Part1. Enter the dease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervet Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Be Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury) Division of Vital Records, P.O. Box 68760, DUM. that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown within 24 hours efter death.

To the Funeral Director: After this certificate has been signs completely filled in by the funeral director, page 2 should be re 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 Tyes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) 2 No Other: 1 Tes 4 Nursing Home 5 Residence 6 Nother (Sc Certification: To 1 Inpatient 2 ER/Outpetient 3□ DOA 28c. Injury at Work? 27. Manger of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as steted.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and manner as steted.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner steted. 29a. Certifier Medicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end tille of certifier U ho completed cause of deeth (Item 23a) (Type, Print)

Registrar DHMH 16 Rev 6/95

State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Hunter 12:45 34 M 19 2008 J ASPER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner C14 Balhmore Homewood CTUNESIS If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ☑ M 2 □ F 213-52**-**0822 Dec.12,1946 Director N.C. 61 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 XYes 2 No Director N/A Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 2740 The Alameda U.S.A. by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1X Never Married 2 ☐ Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Laborer Bethlehem Steel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be May Washington ပ္ Isham Hunter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29445 Tanbark Ct. Goose Creek, S.C. <u>Barbara Boggs/daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 □Burial 2 □ Cremation 3 □ Removal from State CedarHillCemetery Feb22,2008GlenBurnie,MD 4 Donation 5 Dother (Specific 21. Signature of Funeral Service Licen 22. Name and Address of Facility
CALVIN B. SCRUGGS FUNERAL HOME
1412 E. PRESTON ST. BALTO. MD nat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final Moive Failure to months **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HIU- A105 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) signed by the sid be detached f 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anamia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Seiznes s certificate has t irector, page 2 s agnytopenin 1∐ Yes 2 400 Was c e referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Mursing Home 5 Residence 6 Other (Specify) rthis c 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) Injury 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kley mo 31285 2/19/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6401 charles St 4202 MO 21204 K10152 **Begistrar's Signatur** State Registrar

| Decedent's Name (First, Middle, Last) Lorry Last Lorry | | | , | 1 - For State Registrar | State of Mar | - | artment of l | | and Men | | giene | 008 | 05241 |
|--|-------------|--|---------|--|--|-------------------------------------|--|----------------------|---------------------------------|------------------------|----------------|-------------------|--|
| Exhibition The property of th | ļ | | | | | | | | | Date of De | ath | Voor | 3. Time of Death |
| District Control Con | J | | | Larry, t | lall | | | | | | | | 11:16 PM |
| The control of the co | | Examin | er | | 1 1 1 . (| Penter . | 1 1 | _ | | | 4c. Co | unty of Death | |
| 10.5 Size 10.5 Coty 10.5 | | | | XIX | | | | | Min. (| Month, Da | y, Year) | Coui | ntrv) |
| 150. Malling Address (Breat and Number of Rusal Route Number, City or Town, State, Zip Cade) WILLIAM HALL / FATHER P. O. BOX 16 HAGUE, VA 22469 200. Returned of Deposition XX Burels 2 Chemister Service Lecroses 210. BaPTIST CEMETERY 02/16/2008 KINSALE, VA 21. Significant of Function Service Lecroses 22. Significant of Function Service Lecroses 23. Significant of Function Service Lecroses 24. Deposition of Service Lecroses 25. Significant of Function Service Lecroses 26. Returned of Deposition XX Burels 2 Chemister Service Lecroses 27. Significant of Function Service Lecroses 28. Part Februar Between Lecroses 28. Part Februar Between Lecroses 29. Part Februar Between Lecroses 29. Deposition of Function Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 21. Significant Confidence Service Lecroses 22. Significant Confidence Service Lecroses 23. Month Day Vear 10. Leve bird 2 Chemistry 10. Leve bi | | pug 🔏 | | | 1 | 0c. City. Town or L | ocation | | | | | 1. | 10d. Inside City Limits |
| 150. Malling Address (Breat and Number of Rusal Route Number, City or Town, State, Zip Cade) WILLIAM HALL / FATHER P. O. BOX 16 HAGUE, VA 22469 200. Returned of Deposition XX Burels 2 Chemister Service Lecroses 210. BaPTIST CEMETERY 02/16/2008 KINSALE, VA 21. Significant of Function Service Lecroses 22. Significant of Function Service Lecroses 23. Significant of Function Service Lecroses 24. Deposition of Service Lecroses 25. Significant of Function Service Lecroses 26. Returned of Deposition XX Burels 2 Chemister Service Lecroses 27. Significant of Function Service Lecroses 28. Part Februar Between Lecroses 28. Part Februar Between Lecroses 29. Part Februar Between Lecroses 29. Deposition of Function Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 21. Significant Confidence Service Lecroses 22. Significant Confidence Service Lecroses 23. Month Day Vear 10. Leve bird 2 Chemistry 10. Leve bi | | Maryle f sho | o | , | | 7, | | | | | | | |
| 150. Malling Address (Breat and Number of Rusal Route Number, City or Town, State, Zip Cade) WILLIAM HALL / FATHER P. O. BOX 16 HAGUE, VA 22469 200. Returned of Deposition XX Burels 2 Chemister Service Lecroses 210. BaPTIST CEMETERY 02/16/2008 KINSALE, VA 21. Significant of Function Service Lecroses 22. Significant of Function Service Lecroses 23. Significant of Function Service Lecroses 24. Deposition of Service Lecroses 25. Significant of Function Service Lecroses 26. Returned of Deposition XX Burels 2 Chemister Service Lecroses 27. Significant of Function Service Lecroses 28. Part Februar Between Lecroses 28. Part Februar Between Lecroses 29. Part Februar Between Lecroses 29. Deposition of Function Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 21. Significant Confidence Service Lecroses 22. Significant Confidence Service Lecroses 23. Month Day Vear 10. Leve bird 2 Chemistry 10. Leve bi | | r 28a- notif | irect | | | DALITIO | 1 | | | | 10g. Citizen | of What Cou | ntry? |
| 150. Malling Address (Breat and Number of Rusal Route Number, City or Town, State, Zip Cade) WILLIAM HALL / FATHER P. O. BOX 16 HAGUE, VA 22469 200. Returned of Deposition XX Burels 2 Chemister Service Lecroses 210. BaPTIST CEMETERY 02/16/2008 KINSALE, VA 21. Significant of Function Service Lecroses 22. Significant of Function Service Lecroses 23. Significant of Function Service Lecroses 24. Deposition of Service Lecroses 25. Significant of Function Service Lecroses 26. Returned of Deposition XX Burels 2 Chemister Service Lecroses 27. Significant of Function Service Lecroses 28. Part Februar Between Lecroses 28. Part Februar Between Lecroses 29. Part Februar Between Lecroses 29. Deposition of Function Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 21. Significant Confidence Service Lecroses 22. Significant Confidence Service Lecroses 23. Month Day Vear 10. Leve bird 2 Chemistry 10. Leve bi | | th with sit 23a o | al D | 3034 KENYON AVENU | E | | 121 | 15 | | | UNITI | ED STAT | CES |
| 150. Malling Address (Street and Number or Rusal Rouse Namber, City or Town, State, Zip Code) 150. Malling Address (Street and Number or Rusal Rouse Namber, City or Town, State, Zip Code) 150. Malling Address (Street and Number or Rusal Rouse Namber, City or Town, State, Zip Code) 150. Malling Address (Street and Number or Rusal Rouse Namber, City or Town, State, Zip Code) 150. Malling Address (Street and Number or Rusal Rouse Namber, City or Town, State, Zip Code) 150. Malling Address (Street and Number or Rusal Rouse Namber, City or Town, State, Zip Code) 150. Malling Address (Street and Number or Rusal Rouse Namber, City or Town, State, Zip Code) 150. Malling Address (Street and Number or Rusal Rouse Namber, City or Town, State, Zip Code) 150. Malling Address (Street and Number or Rusal Rouse Namber, City or Town, State, Zip Code) 250. Mento of Obspecifies 250 | 36 | rs after dea I", or items kaminer mu | y Funer | XX Never Married 2☐ Married | Armed Forces? 1 ☐ Yes ※※ No If Yes, Give | er in U.S. 13 | | | gin? (Specify i, Puerto Rica | Yes or No in, etc.) | - 1 | Black, White, | etc. |
| 150. Malling Address (Street and Number or Rusal Rouse Namber, City or Town, State, Zip Code) 150. Malling Address (Street and Number or Rusal Rouse Namber, City or Town, State, Zip Code) 150. Malling Address (Street and Number or Rusal Rouse Namber, City or Town, State, Zip Code) 150. Malling Address (Street and Number or Rusal Rouse Namber, City or Town, State, Zip Code) 150. Malling Address (Street and Number or Rusal Rouse Namber, City or Town, State, Zip Code) 150. Malling Address (Street and Number or Rusal Rouse Namber, City or Town, State, Zip Code) 150. Malling Address (Street and Number or Rusal Rouse Namber, City or Town, State, Zip Code) 150. Malling Address (Street and Number or Rusal Rouse Namber, City or Town, State, Zip Code) 150. Malling Address (Street and Number or Rusal Rouse Namber, City or Town, State, Zip Code) 250. Mento of Obspecifies 250 | 9 | 2 hou latura ical E | ted | 15. Decedent's Educ | eation | | | | | | 16b. Kind | of Business/In | dustry |
| 150. Malling Address (Breat and Number of Rusal Route Number, City or Town, State, Zip Cade) WILLIAM HALL / FATHER P. O. BOX 16 HAGUE, VA 22469 200. Returned of Deposition XX Burels 2 Chemister Service Lecroses 210. BaPTIST CEMETERY 02/16/2008 KINSALE, VA 21. Significant of Function Service Lecroses 22. Significant of Function Service Lecroses 23. Significant of Function Service Lecroses 24. Deposition of Service Lecroses 25. Significant of Function Service Lecroses 26. Returned of Deposition XX Burels 2 Chemister Service Lecroses 27. Significant of Function Service Lecroses 28. Part Februar Between Lecroses 28. Part Februar Between Lecroses 29. Part Februar Between Lecroses 29. Deposition of Function Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 21. Significant Confidence Service Lecroses 22. Significant Confidence Service Lecroses 23. Month Day Vear 10. Leve bird 2 Chemistry 10. Leve bi | 215 | thin 7 e. an "n Medi | nple | | | life. | e kind of work done DO NOT use retire | e during most ed) | t of working | | | | |
| 150. Malling Address (Breat and Number of Rusal Route Number, City or Town, State, Zip Cade) WILLIAM HALL / FATHER P. O. BOX 16 HAGUE, VA 22469 200. Returned of Deposition XX Burels 2 Chemister Service Lecroses 210. BaPTIST CEMETERY 02/16/2008 KINSALE, VA 21. Significant of Function Service Lecroses 22. Significant of Function Service Lecroses 23. Significant of Function Service Lecroses 24. Deposition of Service Lecroses 25. Significant of Function Service Lecroses 26. Returned of Deposition XX Burels 2 Chemister Service Lecroses 27. Significant of Function Service Lecroses 28. Part Februar Between Lecroses 28. Part Februar Between Lecroses 29. Part Februar Between Lecroses 29. Deposition of Function Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 21. Significant Confidence Service Lecroses 22. Significant Confidence Service Lecroses 23. Month Day Vear 10. Leve bird 2 Chemistry 10. Leve bi | 2 | led wi lygien her th nt, the | | | | UN | EMPLOYED | 10 Matha | de Nome (Fin | | | | |
| 150. Malling Address (Breat and Number of Rusal Route Number, City or Town, State, Zip Cade) WILLIAM HALL / FATHER P. O. BOX 16 HAGUE, VA 22469 200. Returned of Deposition XX Burels 2 Chemister Service Lecroses 210. BaPTIST CEMETERY 02/16/2008 KINSALE, VA 21. Significant of Function Service Lecroses 22. Significant of Function Service Lecroses 23. Significant of Function Service Lecroses 24. Deposition of Service Lecroses 25. Significant of Function Service Lecroses 26. Returned of Deposition XX Burels 2 Chemister Service Lecroses 27. Significant of Function Service Lecroses 28. Part Februar Between Lecroses 28. Part Februar Between Lecroses 29. Part Februar Between Lecroses 29. Deposition of Function Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 20. Returned Service Lecroses 21. Significant Confidence Service Lecroses 22. Significant Confidence Service Lecroses 23. Month Day Vear 10. Leve bird 2 Chemistry 10. Leve bi | and | t be find Hed out | | , | | | | | , | | maiden Su | rname) | |
| CDonation CDoner (Specify) ZION BAPTIST CEMETERY, 02/16/2008 KINSALE, VA | Ž | should nd Me mark matic | Ļ | | oe. Print) | 19b. Mai | ing Address (Stree | J | | | er. City or To | own. State. Zii | o Code) |
| Continued to Cause (Princil and Continued to Cause (Princil | <u>8</u> | nd 2 saith ar 27 is rrtrau | l, | | ŕ | | - | | | | - | , , , | , |
| CDonation CDoner (Specify) ZION BAPTIST CEMETERY, 02/16/2008 KINSALE, VA | Jre, | es 1 a of Heg | Ý | 20a. Method of Disposition | amanal fram Chaha | 20b. Place of Disp cemetery, cre | osition (Name of ematory or other pla | i | | | | ion - City or T | own, State |
| Physician Medical Examinor Ph | Ē | Page ment ant: If ury o | 1 | | emoval from State | ZION BAP | TIST CEME | TERY 0 | 2/16/2 | 2008 | KINS | SALE, V | A |
| Physician / Modical Examiner The sequence of the sequence of | Balt | permit. Depart Import any inj once, | 5 5 | DIROY D.O | PAY | 1 | 4308 SUIT | LAND I | RD. SU | ITLAN | D, MD | | |
| Physician (Modical Examiner) Part Implementate Cause (infant and a consequence of): | | | | 23a. Part1. Enter the disease, or compli shock, or heart failure. List only or | cations that caused the cause on each line. | ne death. Do not ei | nter the mode of dy | ing, such as | cardiac or res | spiratory a | rrest, | | Interval Between |
| Examiner Part | | | disease or condition | | | Adenocar | cinomi | a | | | | Onset and Death |
| Cause (Disease or Thur) Cause (Disease or Thu | | | | resulting in death) | Due to (or as a | consequence of): | | | | | | | |
| Cause (Disease or Thur) Cause (Disease or Thu | | ** | er | Sequentially list conditions, if any leading to immediate | Due to (or as a o | consequence of): | | | | | | | |
| The completion of cause of light of the completion of cause of light of the cause of leath of light of the cause of leath of light of the cause of leath of light of the cause of leath of light of the cause of leath of light of the cause of leath of light of the cause of leath of light of the cause of leath of light | | uted d ansit | mim | Cause (Disease or injury | | | | | | | | | |
| The composition of the control of | oʻ | e exec an an irial-tr | | resulting in death) Last | Due to (or as a | consequence of): | | | | | | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death examiner of Death (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 27. Manner of Death (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred work? 1 Yes 2 No 28d. Describe how injury occurred work? 1 Yes 2 No 28d. Describe how injury occurred work? 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) | 876 | ate be hysici the bu | lical | d | | | | | | | | | |
| 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death examiner of Death Solicide to Homicide 28. Place of Death (Check only one) 27. Manner of Death North of Death of D | 9 | certific nding pl | J/Mec | | | | | | | | 23d | . Date of deliv | erv |
| 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death examiner of Death (Month, Day Year) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 27. Manner of Death (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred work? 1 Yes 2 No 28d. Describe how injury occurred work? 1 Yes 2 No 28d. Describe how injury occurred work? 28d. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) | o. | the death by the atte ached for | hysicia | in the past 12 months? 1 ☐ Yes 2 ☐ No | 4□Pregnant at tir | | | cy | | | | Month | Day Year |
| 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death examiner of Death Solicide to Homicide 28. Place of Death (Check only one) 27. Manner of Death North of Death of D | | ss tha gned l | | | tributing to death but | not resulting in the | underlying cause gi | iven in Part I. | | 23e. Did t | obacco use | contribute to t | the cause of death? |
| 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death examiner of Death Solicide to Homicide 28. Place of Death (Check only one) 27. Manner of Death North of Death of D | g | equire | ted | Human Immunoc | deticiency | Virus | | | - | 1 🗆 ' | Yes 2□1 | No 3∭X Pro | bably 4 □Unknown |
| 25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death examiner of Death Solicide to Homicide 28. Place of Death (Check only one) 27. Manner of Death North of Death of D | Ş Ş Ş | e law r has be e 2 sh | nple | | | | | | _ [| autor | osy | prior to co | opsy findings available impletion of cause of |
| The state of the s | <u>8</u> | | | | | | | | | | | deatn? 1 ☐ Yes | 2 X No |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | siciar certif rector | | examiner? | ospital: | 2 □ EB/Outpotis | et all pos Ot | hor: | | | | Tou 10 1 | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | ō | y Physer this eral di | | 27. Manner of Death | 28a. Date of Injury | 28b. Time | III 3LI DOA | 4 LI NUI | | | | | fy) |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | <u></u> | nding ath. r: Afte | atior | | (Month, Day) | /e <i>ar)</i> Injury | | | No | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | <u>N</u> | r Atte ter dea irecto | tifica | | 28e. Place of injury building, etc. | - At home, farm, s | treet, factory, office | | | | | lumber or Rur | al Route Number, |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | urs aft | | | | | | | 10 | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | Hosp 24 ho Fune etely f | dical | (Check only 2 Medical Examil | ner: On the basis of e | xamination and/or | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | To the within To the Somple | Me | 29b. Signature and title of certifier | | | 29c. Licen | se number | | | 29d. Date s | igned (Month, | Day, Year) |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cheryl Hepp, MD 22 South Greene Street, Baltimore, MD 31201 | | | | · Clubell | MM | | P19 | 9729 | | | Febru | ary 11, | 2008 |
| | | | | A | mpleted cause of dea 2 South G | th (Item 23a) (Type reene Stre | Print) H, Balti | more, i | e am | 1201 | | | |
| State Registrar FEB 2 1 2008 Registrar's Signature | | | | | Registrar's | | W. | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Amend #15, perFH, g877 3.5.08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** RUTH MAE 10.50AM HARRIS FE 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COLUMBIA HOWARD HOWARD COUNTY GENERAL HOSPITAL 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 🔀 F New York **Director** D18-26-3363 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at Columbia MD Howard 1√Yes 2□No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 6320 Frostwork Row 21044 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes ≥ 2 X No If Yes, Give Year or Dates; 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2K Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) D.C. Government Nurse Educator 5th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Josephine Demby Nathaniel Cipriani 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6320 Frostwork Row, Columbia, MD 21044 Jesse Harris/ husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or ot once, 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Columbia Memorial Park 2-25-2008 Clarksville, MD 21029 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home of MD 21. Signature of Funeral Service Licensee DORAY 4308 Suitland Road, Suitland, MD 20746 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** espiraton /Medical Due to (or as consequence of): Examiner neumonia Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a nonsequence or) Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 2200 been signed by the should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by lling, 1 TYes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 autopsy performed: certificate To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 ☐ Pending investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as sauce.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Feb. 18, 2008 D 36845 MD, FCCP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mar-Chr Liquyen, MD, FCCP 7350 31. Date filed (Month, Day Year) 32 Registrar's Signature State Registrar 2008

| | | | For State Registrar | State of | Maryland | d / Depa | artment | t of H | ealth a | and M | | giene | | 05243 |
|------------|---|----------------|---|--|------------------------------------|---|------------------------------|--------------------------|---------------------------|------------------------|---------------------------------------|----------------------------|---|---|
| 1 | - PT | | Decedent's Name (First, Middle | , Last) | | | | | | | 2. Date of De | ath | | 3. Time of Death |
| | Physici /Medic | | Alphonso Hender | son | | | | | | | Month Februai | Day | y Year 6, 2008 | 0025 a ^M |
| | Examin | | 4a. Fecility Name (If not institution | | ber) | | 4b. City, | Town, or | Location of | of Death | 100100 | | . County of Deatl | |
| 7.5 | | | Prince George's | | | | Cheve | | | | | | ince Ge | |
| | Funeral | n i | 5. Social Security Number | 6. Sex | 7. Age (In yrs. ia | as <i>t birthd</i> a <i>y)</i> 68 Yrs. | If Under Months | 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Bir 06-29- | th Yo ^Y ear) | Co. | nplace (State or Foreign untry) |
| | Director | | 229-48-7449 Usual Residence of Decedent | | | | | | | | 00-29-1 | 1939 | ATI | ginia |
| | yland now | | 10a. State 10b. County | | 10c. City | , Town or Lo | ocation | | | | | | | 10d. Inside City Limits |
| | a-f et | ctor | MD Prince | George's | Land | over | | | | | | | | 1 X Yes 2 □ No |
| | or 28 | Director | 10e. Street and Number | | | | 10f. Zip | Code | | | | 10g. Cit | izen ol What Co | untry? |
| | death with the Maryland ms 23a or 28a-f ehow rrust be rediffed at | rail | 2106 Oregon Ave | | | | 2078 | | | | | JSA | | |
| 36 | 2 should be filed within 72 hours after death with the Marylar and Mental Hygiene. In marked other than "natural", or Items 23e or 28a-f ehow aumatic event, the Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☒ Marri 3 ☐ Widowed 4 ☐ Divorced | Armed For | 2 (X No 9 | | Was Deced If Yes, spec | rfy Cuba | n, Mexicar | gin? (Spa n, Puerto | ecify Yes or No Rican, etc.) |)- | 14. Race - Amer Black, White Specify: Bla | e, etc. |
| 1215-0036 | 2 hou | edt | 15. Decedent | 's Education | 103. | 16a. Dece | dent's Usua | I Occupa | ition | | | 16b. K | ind of Business/ | ndustry |
| 7 | hin 7. | Completed | (Specify only highes Elementary/Secondary (0-12) | t grade completed) College (1- | 4or 5+) | (Give life. | kind of wor DO NOT us | rk done a se retired, | <i>luring</i> mos | t of work | ing | | | |
| N | ed wit | Con | llth | | | Trucl | k Driv | /er | | | | Fede | eral Gov | ernment |
| | be file tal Hy d oth | Be | 17. Father's Name (First, Middle, I | | | | | | | | (First, Middle, | | Sumame) | |
| <u> </u> | | T _o | Samuel Henderson | | | | | | | | nknown) | | | |
| Maryland | | | 19a. Informant's Name/Relationsh Jacquline Hender | | | 1 | - | | | | dover, | | or Town, State, 2 20785 | îp Code) |
| | 1 and Health Iom 27 | ij | 20a. Method of Disposition | Boll, Will | | ace of Dispo | National Colonia Colonia | | | | Date | | ocation - City or | Town, State |
| saitimore, | permit. Pages i Department of H Important: If Ite any injury or ot once. | | 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp | | nate | emetery, crei .co1n 1 | | | F | _20_ | 2008 | | tland, M | |
| | artme ortan injur | | 21. Signature of Funeral Service I | | LITI | | | | | | The second second | | | me of MD |
| ă | Dep Per Per Per Per Per Per Per Per Per Per | | DIR.OK | D Chr. | 1 | | | | | | | | Marylan | |
| - 14 | t. t ₂ | | 23a. Part1. Enter the disease, or shock, or heart failure. List | complications that da | used the death ich line. | . Do not en | er the mode | e of dying | g, such as | cardiac | or respiratory a | rrest, | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | | | 0.20xx A.3 | reat | | | | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | a. Cardi | | | | | | | | | | |
| | . Examiner | h. | Sequentially list conditions, | b | Myocar | | nfaro | ction | 1 | | | | | |
| | ed sit | niner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (c | or as a consequ | ience oi): | | | | | | | | |
| • | xecul and al-trar | Examin | that initiated events resulting in death) Last | c. Due to (d | or as a consequ | ience of): | | | | | | | - | |
| 2/00 | icate be executed physiclen and s the burial-transit | dicai E | | | | | | | | | | | | |
| ρ | g phy as the | edic | | 0. | | | | | | | | | | |
| C. BOX | that the death certificate be executed by the attending physicien and detached for use as the burial-transit | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | | nth 2 ☐ Fetal ant at time ol de | death 3[| Ectopic pro | | | | | | 23d. Date of deli Month | very Day Year |
| Ž | requires that the een signed by th hould be detache | by Ph | Part II. Other significant condition | ns contributing to de | ath but not resu | Iting in the u | nderlying ca | ause give | n in Part I | | 23e. Did t | obacco i | use contribute to | the cause of death? |
| cords | w requires that been signed be should be det | ed | Hypertension | | | | | | | | 10 | Yes 2 | □No 3□Pr | obably 4 Nuknown |
| T C | > 0 % | Completed | Diabetes | | | | | | | | 24a. Was autop perfo 1 ☐ Yes | | prior to death? | topsy findings available completion of cause of |
| VII | cian: ertific actor, | Be | 25. Was case referred to medical examiner? | | | | | | | of Deatl | Check only | one) | | |
| 5 | Physic this c | J | 1 ☐ Yes 2 🛣 No | | - | ER/Outpatier | | | 4 🗆 140 | | | | 6 Other (Spec | city) |
| | Attending Physician: Ir death. ector: After this certific: by the funeral director, | tion: | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig | | f Injury n, Day Year) | 28b. Time o Injury | M Z | 8c. Injury Work | at ? ∕es 2 🗆 | | 28d. Describe | now inju | ry occurred | |
| UNISION | deat ctor: y the | ertificati | 3 Suicide 6 Could n | not be age Place | of Injury - At hou | me, farm, str | | | | | 281. Location (| Street ar | nd Number or Ru | ral Route Number, |
| 5 | al or after | erti | 4 Homicide | buildin | g, etc. (Specify |) | | | | | City or To | wn, State | 9) | |
| | To the Hospital or Attending Physician: The lav within 24 hours after death. To the Funaral Director: After this certificate has completely filled in by the funeral director, page 2. | edical C | 29a. Certifier (Check only one) Certifyin 2 Medical I | g Physician: To the Examiner: On the ba and mann | sis of examinati | wledge, deat ion and/or in | h occurred a vestigation, | at the tim | e, date an pinion, dea | d place, th occurr | and due to the red at the time, | cause(s date and |) and manner as d place, and due | stated. to the cause(s) |
| | within To th compl | Me | 29b. Signature and title of certifier | 0 - | A | 4 | 29c | License | number | . ^ | , | 29d. Da | te signed (Monti | n, Day, Year) |
|) | | | 1 Ax | 1 W. C | net | KM | D | D 6 | 272 | 56 | 4 | 21 | 17/08 | |
| | | | 30. Name and address of person v | who completed cause | ol death (Item | 23а) (Туре, | Print) | | | - | | | | |
| | | | A.M. Mehta, MD, | | | | | | olle; | ge P | ark, Ma | ryla | ind, 202 | 40 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) FEB 2 | | sistrar's Signat | ure / | book | 1 | | | | | | |

1 Decedent's Name (First Middle Last)

Physician

/Medical

| Certificate of Death | Beg No 2008 | |
|--|-------------|---|
| State of Maryland / Department of Health and N Certificate of Death | | 1 |

05244

| | - | | |
|-----------------|--------|------|-----------------|
| 2. Date of Deat | n | | 3. Time of Deat |
| Feb. 16 | . 2008 | Year | 2:15 P |

4b. City, Town, or Location of Death

Catonsville

4c. County of Death Baltimore

GATL MARTE HARDESTY

If Under 1 Year | If Under 24 Hrs. Days Hours

8. Date of Birth (Month, Day, Year) Jan 28, 1950 Birthplace (State or Foreign Country) Maryland

White

10d. Inside City Limits

1XYes 2 □ No

М

Baltimore

10f. Zip Code

10g. Citizen of What Country? USA

Specify:

21226 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

14. Race - American Indian, Black, White, etc.

16a. Decedent's Usual Occupation (Give kind of work done during most of working lite. DO NOT use retired) 16b. Kind of Business/Industry

Nursing Home 18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Flack

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 2/20/08

20c. Location - City or Town, State Marriottsville, Md.

Crestlawn Mem Gdns

22 Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Baltimore, Md. 21225-1856

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

80923

Vascular disease

23d. Date of delivery

3 □Ectopic pregnancy 5 ☐ Other (specify)

26. Place of Death (Check only one)

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed' 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No

25. Was case referred to medical 1 Yes 2 No

27. Manner of Death 1 Natural

5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3□ Suicide determined 4 ☐ Homicide

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only one)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 021649 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3455 WILKENS AVE BACTIMORE MD 21229 SAMBANDAM BASKARAN M.J

31. Date filed (Month, Day, Year)



DHMH 17 Rev 1/2001

State

Registrar

To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, F

Be

Certification: To

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? [] [] [05245 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2008 ebyan 18 Joyce S. 3:30PM Dorothy 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2√2 F 220-30-7471 MD 97 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits NA Baltimore 1 XYes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21215 3218 Sequoia Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black Wildowed 4 □Divorced

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28s-f show other treumatic event, the Madical Examinations must be nightled at Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Direct

Funeral

10a. State

MD

Funeral

Director

Physician /Medical Examiner

> attending physicien and for use as the burial-transit certificate has been signed rector, page 2 should be det

Division of Vital Records, P.O. Box 68760,

| ZZ TITLE TO TE TO | Teal of Dates. | | | | | |
|---|--|---|---|--|--|---|
| 15. Decedent's E (Specify only highest gr | ducation ade completed) | 16a. Decedent's Usual O (Give kind of work d life. DO NOT use n | ccupation one during most of wo | 16b. Kind of Business/Industry | | |
| Elementary/Secondary (0-12) 12th grade | College (1-4or 5+) 2yrs | Nurse | | | Hospi | tal |
| 7. Father's Name (First, Middle, Las | 1) | | 18. Mother's Na | me (First, Middle, Mai | den Sumame) | |
| James Parker | | | _ | e Dorsey | | |
| 19a. Informant's Name/Relationship | (Type, Print) | 19b. Mailing Address (St | reet and Number or F | Rural Route Number, C | ity or Town, State, a | Zip Code) |
| Yvonne Cyrus-I | aughter | 5600 Cadi | llac Ave | | ore, Md | 21207 |
| 0a. Method of Disposition | | Place of Disposition (Name of semetery, crematory or other | of lacel | Date 200 | . Location - City or | Town, State |
| 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci | fy) Nev | v Cathedral | 2/2 | 2/08 Ba | altimore | , Md |
| 21. Signature of Funeral Service Lice | nsee | 22. Name and A March F 4300 Wa | ddress of Facility /H West bash Ave | , Baltimo | ore, Md | 21215 |
| 23a. P = 11. En en the disease, or con sh ck, or leart failure. List only | pplicatio hat caused the deate | | | | | Approximate Interval Between Onset and Death |
| mmediate Cause (Final disease or condition | Bact | erema | | | | 7 20115 |
| esulting in death) | Due to (or as a conseq | uence of): | | | | 1000 |
| | | | | | | |
| equentially list conditions, any, leading to immediate | b. Due to (or as a conseq | uerna of): | | | | |
| ause. Enter Underlying dause (Disease or injury | 1 | | | | | |
| nat initiated events | C | 0 | | | | |
| esuting in death) Last | Due to (or as a conseq | uence of): | | | | |
| | d | | | | | |
| | | | | | | |
| F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome of pregnating the control of t | f death 3 ☐ Ectopic pregn | | | 23d. Date of del Month | ivery Day Year |
| art II. Other significant conditions | contributing to death but not res | ulting in the underlying caus | e given in Part I. | 23e. Did tobac | | the cause of death? |
| | | | | 24a. Was an autopsy performed | prior to death? | utopsy findings available completion of cause of 2 No |
| 5. Was case referred to medical | | | OC Diseased De | eath Check only one | .140 10163 | 20140 |
| examiner? | Hospital: | EDIO ALLES ESTATE | | | . 7. | |
| 7 Manger Death | Inpatient 2 | ER/Outpatient 3 DOA 28b. Time of 28c. | 4 🗌 Nursing | Home 5 Residence | e 6 ∐Other (Spe | city) |
| Natural 5 Pending | 28a. Date of Injury (Month, Day Year) | Injury | Injury at Work? | 28d. Describe how i | njury occurred | |
| 2 Accident investigation | | М | 1 ☐ Yes 2 ☐ No | | | |
| 3 Suicide 6 Could not be determined | 28e. Place of Injury - At he building, etc. (Specify | ome, farm, street, factory, of | fice | 28f. Location (Stree City or Town, S | t and Number or Ru tate) | ıral Route Number, |
| | | | | 1 | | |
| 29a. Certifier (Check only one) Certifying Place 2 Medical Example 1 | hysician: To the best of my kno miner: On the basis of examina and manner stated. | wledge, death occurred at the tion and/or investigation, in a | ne time, date and plac my opinion, death occ | e, and due to the caus turred at the time, date | e(s) and manner as and place, and due | stated. to the cause(s) |
| 9b. Signature and vitle of certifier | | 29c Lie | cense number | Poc | Date signed (Mont | h Day Yearl |
| 1 /2 | 2- D | 7 | moff of | 2 10 | | |
| 3- | mD. | | 0000 | 1 /2 | buasy | mD 2121 |
| 30. Name and address of person who | completed cause of death (Item | 23a) (Type, Print) | 2.1 | 1 0 1 | | / |
| 3hane . D. | 2333 N | Calvat | Stract | , Balt | more | mD 2121 |
| An Low | 1 0000 | Cr. ven | 04,0 | 1 4 -01 | 1 | 1-10-1-11 |

State Registrar

32. Registrar's Signature

-Shary, Ros 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** the 17,200 ebrucing /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Bon Secour Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🔀 F 212-22-3135 Director 84 VA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 XYes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 7 21217 U.S.A. 806 North Appleton Street Completed by Funeral ıral", or items 2 I Exaπiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Black 3√ Widowed 4 Divorced "natural", er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6th grade Housewife Home na other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fil iment of Health and Mental H iant: If item 27 is marked oth James Rich Lillian Stuever 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21215 3510 Liberty Heights Ave, Baltimore, Mary R. White-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important; If I = 5 2/22/08 Woodlawn Baltimore Co, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H West 4300 Wabash Av 21. Signature of Funeral Service Licer Wabash Ave, 21215 Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of) Examiner Gequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 1⊟ Yes or Attending Physician; the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient To 1 | Inpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) Injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Pate signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 1/2001

State 31. Date filed (Month, Day, Year)
gistrar FFR 2 1 200

MAR



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Febaraa **Physician** 01:35M 2008 Imogene S. Jones /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NICOMICS Carll SAIUBUU 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of 18 Country)
March 16,1922 Delaware 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🛛 F 85 Director 325-28-4779 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f sh edical Examiner must be notified 1 Tyres 2 □ No Director Wicomico MD Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 800 Hanover Street #B 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nurse Pvt. Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Larry E. Jones Clara Wright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David L. Alderfer/Nephew 546 Heflin Rd., Schwenksville, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Howard University 2/14/08 Washington, DC 4 XDonation 5 ☐ Other (Specify) 21. Signature of Euneral Corvice Licensee 22. Name and Address of Facility Austin Royster Funeral Home 3821 14th Street, NW, Washington, DC 20011 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hand failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transi Due to (or as a consequence of): ate has been signed by the attending physician page 2 should be detached for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4□Pregnant at time of death 9□Unknown 5 Other (specify) 1 ☐ Yes 2 💢 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident **Director:** 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053394 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Pemberton Salisbury, md. 21801 Anthony I-Rey 205 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

1-

Physician

/Medical

Examiner

To Be Completed by Funeral Director

Funeral

Director

Physician

Medical Certification: To Be Completed by Physician/Medical Examiner

BAHRAM PISHDAD,

31. Date filed (Month, Day, Year) FEB 2 1

| Please | Type or Print i | | | | | | _ | | Legible. | |
|--|---|---|---------------------------|---------------------|------------------------------------|-----------|------------------------------|--------------------------|------------------------------------|---|
| 1 - For State Registrar | State of Mary | | artmen <i>rtificat</i> | | | l Me | - | giene Reg. No. | 2008 | 05248 |
| 1. Decedent's Name (First, Middle, La | ast) | | | | | 2. | . Date of De | | | 3. Time of Death |
| Willia Beatrice J | | | | | | | Month ebruai | | 2, 2008 | 7:20 a ^M |
| 4a. Facility Name (If not institution, given Pineview Nursing | · · | | 4b. City, | | Location of Dea | ath | | | County of Dea | |
| | | yrs. last birthday) | If Under | 1 Year | If Under 24 H | | . Date of Bir | th | Ince Ge | rthplace (State or Foreign |
| 577-22-5245 | 1□M 2X1F | 91 _{Yrs.} | Months | Days | Hours Mi | | (Month, Da 0-2-19 | | | country) |
| Usual Residence of Decedent 10a. State 10b. County | 100 | c. City, Town or Lo | cation | | | | | | | 10d. Inside City Limits |
| | | | | | | | | | | 1 ∑Yes 2 □ No |
| 10e. Street and Number | George S F | ort Wash: | 10f. Zip | | | | | 10g. Citi | zen of What C | country? |
| 3013 Melisa Drive | | | 207 | | | | | USA | | · |
| 11. Marital Status | 12. Was Decedent Ever Armed Forces? | | Was Dece | dent of His | spanic Origin? | (Specif | y Yes or No | | 14. Race - Am | |
| 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 Yes 2 No If Yes, Give Year or Dates: | | ii ves, spe 1 □ Yes | _ | Specify: | erto Aic | can, etc.) | | Black, Wh | |
| 15. Decedent's E (Specify only highest gr | ducation ade completed) | 16a. Dece | dent's Usua kind of wo | al Occupa | tion uring most of w | vorkina | | 16b. Kii | nd of Business | s/Industry |
| Elementary/Secondary (0-12) 12th | College (1-4or 5+) | | _ | se retired) | uring most of w | , or ming | | | 1.0 | |
| 17. Father's Name (First, Middle, Last | t) | Accour | iting | | 18. Mother's N | lame (F | | | | vernment |
| Willie Merriweth | er | | | | Pernin | na (| Cunnin | gham | 1 | |
| 19a. Informant's Name/Relationship | (Type. Print) | 19b. Mailir | ng Address | (Street a | nd Number or | | | | | Zip Code) |
| Paula Proctor/dau | | 3013 | Meli | sa_Dr | ive, F | ort_ | Washi | ngto | n,_MD_ | 20744 |
| 20a. Method of Disposition 1 | _nemoval mont state | Ob. Place of Dispo cemetery, cree Lincoln 1 | | | | Date 1-2(| _ | | cation - City o $1 { m and}$. 1 | r Town, State Mary Land |
| 21. Signature of Funeral Service Lice | CRAY | | | | of Facility 1 | | | s Fu | neral | Home of MD. |
| 23a. Part1. Enter the disease, or con shock, or heart failure. List only | nplications that caused the one cause on each line. | death. Do not ent | er the mod | le of dying | , such as cardi | iac or r | espiratory a | rrest, | | Approximate Interval Between |
| Immediate Cause (Final disease or condition resulting in death) | a. CARDIOPULMO | | ILURE | | | | | | | Onset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. HYPERTENSIC Due to (or as a cord of DIABETES M | RTERY DI sequence of). ON sequence of): | SEASE | | | | | | - | |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcome pf pr 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown | Fetal death 3 | Ectopic pr Other (sp | | | | | 2 | 3d. Date of de | elivery Day Year |
| Part II. Other significant conditions ATRIAL FIBRILLAT | • | t resulting in the u | nderlying c | ause give | n in Part I. | | | obacco u Yes 2[| | to the cause of death? |
| DEMENTIA | | | | | | - 14 | 24a. Was | | 24b. Were a | autopsy findings available completion of cause of |
| | | | | | | | 1□ Yes | 2 X No | death? 1 ☐ Ye | |
| 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No | Hospital: | 0EED/C : // | | Otho | 26. Place of D | | | | | |
| 27. Manner of Death 1 Natural 5 Pending | 28a. Date of Injury (Month, Day Yea | 2 ER/Outpatien 28b. Time of Injury | f 2 | 28c. Injury Work | at ? | | 5 Resid | | Other (Sp occurred | ecify) |
| 2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined | 00 00- 01 | At home, farm, str pec <i>ify)</i> | M eet, factory | | es 2□No | 28f | Location (S City or Tow | Street and vn, State, | d Number or F | Rural Route Number, |
| 29a. Certifier 1 CertifyIng Pl | hysician: To the best of my miner: On the basis of exa and manner stated. | knowledge, death | h occurred vestigation | at the tim | e, date and pla inion, death oc | ace, and | d due to the at the time, | cause(s) date and | and manner a place, and du | as stated. ue to the cause(s) |
| 29b. Signature and title of certifier | | | 290 | c. License | number | | | 29d. Dat | e signed (Mor | nth, Day, Year) |

State

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. registrar's Signature

MD

D51520

1328 SOUTHERN AVENUE #310, WASHINGTON, DC 20032

February 15, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 5:33 A M February 2008 Jane L. King 17, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Harford Bel Air Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2**X**□ F Director 219-34-8942 Usual Residence of Decedent 74 April 3,1933 Maryland should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2XXNo Director Harford Kingsville Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 803 Karylou Circle USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: White 1 ☐ Yes 2 🔯 No Specify Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Co. Schools 12 <u>Teacher</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental em 27 is marked o and 2 should be Dorothy Hall ပ္ Samuel Lyons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert King Circle Kingsville, Maryland 21087 (husband) 803 Karylou permit. Pages 1 an Department of Heal Important: If item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) any injury or 02/20/2008 Huntingtown, Maryland Miranda Cemetery 21. Signature of Funeral Sovice Licensee 22. Name and Address of Facility 9705 Belair Road Baltimore, Maryland 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? Yes 2 XNo death? 1 ☐ Yes 2 ☐ No 1∐ Yes Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1. Naturai Injury 5 Pending To the Hospital or Attendi within 24 hours at er death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Year)

SCME

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

29b. Signature and

tle of certifie

ress of person

2008

Mary G/Ripple MD.

31. Date filed (Month, Day Year)

who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

3. Registrar's Signature

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

February 19, 2008

DALE KESSELKING

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

| | | Please T | ype or Prin | t in Blac | ck Indelil | ole Ink. | Ensure A | II Copies | Are | Legible. | |
|--|------------------|---|--|--------------------------------|---|-------------------------------|--|---------------------------------------|-----------------|--|---|
| | | For State | State of Ma | ryland / | | | | Mental Hy | giene | 2008 | 05251 |
| | | Registrar 1. Decedent's Name (First, Middle, Last) | | | Certific | ate of I | Death | 2. Date of De | Reg. No |). V V V | 3. Time of Death |
| Physicia | | | sselrino | ~ | | | | Month Janua | Da | 26,2008 | 12:00 P ^M |
| /Medic Examin | | 4a. Facility Name (If not institution, give s | | 9 | 4b. C | ity, Town, or | r Location of Death | | | . County of Death | 12:00 1 |
| Funeral Director | | North Arundel Res. Social Security Number 485-50-3350 | | on Ce (In yrs. last b | | der 1 Year | Burnie If Under 24 Hrs. Hours Min. | 8. Date of Bir (Month, Da | th ay, Year, | | ndel lace (State or Foreign owa |
| | | Usual Residence of Decedent | | | | | | Aug. | 20, | | |
| after death with the Maryland or items 23s or 28s-f show primer must be notified at | tor | NE Lancast | er | 10c. City, Tov | wn or Location Linco | ln | | | | 1 | 0d. Inside City Limits 1 Yes 2 No |
| or 28g | lrec | 10e. Street and Number | | | 10f. | Zip Code | | | 10g. Ci | itizen of What Cour | ntry? |
| ath wi | rai | 2720 South 10th | | | | 685 | | | - 1 | USA | |
| after de or items | Funerai Director | 11. Marital Status 1 ☐ Never Married 2 ☐ Married | 12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N | | | | ispanic Origin? (Sp an, Mexican, Puerto | pecify Yes or No o Rican, etc.) |)- | 14. Race - Americ Black, White, | etc. |
| rai', o | ٥ | 3 X Widowed 4 □ Divorced | If Yes, Give Year or Dates: | | 1 □ Ye | 2 X No | Specify: | | | Specify: Wh | Lte |
| should be filed within 72 hours nd Mental Hygiene. marked other than "natural; , umatic event, the Medical Exa | Completed | 15. Decedent's Educ (Specify only highest grade | completed) | | a. Decedent's U (Give kind of life. DO NO | work done o | during most of wor | king | 16b. F | (ind of Business/In | dustry |
| d with giene. | mo | Elementary/Secondary (0-12) 12 | College (1-4or 5- | +) | Pipe | Fitt | er | | | Pvt. | |
| permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than eny injury or other traumatic event, Italy ORE. | Be | 17. Father's Name (First, Middle, Last) | | | | | 18. Mother's Nam | | | | |
| thould ad Mer marke matic | ို | Carl G. Kessel 19a. Informant's Name/Relationship (Type) | | 19 | b Mailing Addr | ess (Street | Wilma and Number or Ru | | Majo | | Code) |
| and 2 s ealth ar m 27 is her trau | | Sherie Whilford/ | | r Z | 720 SO | uth 1 | 0th Sti 68502 | | o., o, | or Town, State, Zip | |
| of He of He if item or othe | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R | | 20b. Place cemete | Incoln of Disposition (ery, crematory | Name of or other place | ca) | Date | 20c. L | ocation - City or To | own, State |
| t. Pag ntment rtant: | | 4 ∑Donation 5 ☐ Other (Specify) | | Howan | cd Uni | versi | Lty 1/27 | 7/08 | | shington | |
| Departiment of the post of the | | 21. Signature of Funeral Service License | 0 | | | | | | | | eral Home DC 20011 |
| | | 23a: Part1. Enter the disease, or compli- shock, or heart failure. List only on | cations that caused | the death. Do | | | | | | | Approximate Interval Between |
| Physician | | Immediate Cause (Final disease or condition | | | ceph | alogo | offing | | | | Onset and Death |
| /Medical Examiner | | resulting in death) | Due to (or as a | consequence | of): 0 | | | | | | |
| | je | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | |
| ficate be executed physicien and G | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | | | 4) | | | | | | |
| be ex | - | | Due to (or as a | consequence | or): | | | | | | |
| ificate g phys | edica | d | | | | | | | | 17. | |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificete has been signed by the altending physicial completely filled in by the funeral director, page 2 should be detached for use as the but | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 3c. If yes, outcome of 1□Live birth 2 4□Pregnant at t 9□Unknown | 2 🗌 Fetal deat | h 3∏Ectopi 5∏Other | pregnancy (specify) | , | | | 23d. Date of delive Month | ery Day Year |
| s that in the plant by Ph | Part II. Other significant conditions con | tributing to death bu | t not resulting | in the underlyin | g cause giv | en in Part I. | 23e. Did | tobacco | use contribute to the | ne cause of death? |
| n requires that the de been signed by the s should be detached | | | | | | | | 10 | Yes 2 | 2□No 3□Prob | ably 4 Dunknown |
| The law rate has be page 2 shi | Completed | 1 | | | | | | 24a. Was auto perfe 1 ☐ Yes | psy ormed? | prior to co death? | psy findings available impletion of cause of 2 No |
| ician: sertific ector, | Be | 25. Was case referred to medical examiner? | ospital: | | | 100 | 26. Place of Dea | th (Check only | one) | | |
| Phys | 5 | 1 ☐ Yes 2 🔀 No '' 27. Manner of Death | 1 ☐ Inpatier 28a. Date of Injury | | Outpatient 3 Time of | DOA Othi | 4 US Nursing H | ome 5 Res | | 6 ☐Other (Specif | y) |
| ending ath. or: After ne fune | ertification: | 1 Natural 5 Pending 2 Accident investigation | (Month, Day | | Injury M | Worl | k? Yes 2 □ No | 2021 2000120 | | .,, | |
| or Att | ertific | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Inju building, etc | ry - At home, f . (Specify) | farm, street, fac | tory, office | | 28f. Location (City or To | | nd Number or Rura (e) | I Route Number, |
| To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | edicai C | 29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin | ician: To the best of er: On the basis of and manner stat | examination a | ge, death occur ind/or investiga: | ed at the tin ion, in my o | ne, date and place pinion, death occu | , and due to the rred at the time, | cause(s | s) and manner as s nd place, and due to | tated. o the cause(s) |
| To th withir To th comp | Me | 29b. Signature and title of certifier | | | | 29c. Licens | | | | ate signed (Month, | |
| | | Milelon | epul | One of the second | | 7). | -4052 | 1 | reb | may 11, | 5008 |
| b | | 30. Name and address of person who co | | eath (Item 23a) |) (Type, Print) | 325 - | 1 Burni | 1 Drue | 2 | may 11, 3 Soute 7 | , D. J. |
| Sta | te | 31. Date filet Manth Day, Year | 32. Registra | r's Signature | and a | 0 | | () | | | |

| | | | _ State | of Maryland / Dep <i>Ce</i> | artment of He artificate of D | ealth and Ment Leath | | | 05252 | |
|----------------|---|---------------------|---|--|---|---|---------------------------------------|--|--|--|
| | | 11 | Registrar 1. Decedent's Name (First, Middle, Last) | | ranoate of B | 2. Da | Reg. Nate of Death | | 3. Time of Death | |
| | Physici /Medi | | Morris Kilberts | | | | | 19 2008 | 6:00 A ^M | |
| | Examir | | 4a. Facility Name (If not institution, give street and n | | | | | | 1 | |
| | | 4 | MILFORD MANOR NURSING 5. Social Security Number 6. Sex | HOME 7. Age (In yrs. last birthday) | BALTIMOR | | ate of Birth | BALTIMOR | | |
| 2 | Funeral Director | | 219-05-8582 1M № 2□F | 86 Yrs. | | Hours Min. 12 | onth, Day, Year /29/192 | r) Cou | nplace (State or Foreign intry) MD | |
| | land ow | | 10a. State 10b. County | 10c. City, Town or L | ocation | | | | 10d. Inside City Limits | |
| | Mary a-f sh ified | ctor | MD BALTIMORE | | BALTIMORE | | | | 1 □Yes 2 XNo | |
| | ith the or 28 | Sire | 10e. Street and Number | | 10f. Zip Code | | 10g. C | itizen of What Cou | untry? | |
| | ath wi | la | 7 SLADE AVENUE, APT. | | | 1208 | | USA | | |
| 5-0036 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | by Funeral Director | 11. Marital Status 1 Never Married 2 Married 1 Never Married 3 Married 1 Never Married 4 Divorced | : 2 □ No Give | ·V | panic Origin? (Specify Y Mexican, Puerto Rican Specify: | es or No- , etc.) | 14. Race - Amer Black, White Specify: WH | | |
| 5-0 | 72 hc 'natur dical | Completed | 15. Decedent's Education (Specify only highest grade completed | 16a. Dece | edent's Usual Occupati e kind of work done du DO NOT use retired) | ion ring most of working | 16b. I | Kind of Business/I | ndustry | |
| 2121 | within ene. than " | ldm | Elementary/Secondary (0-12) College | (1-40r 5+) | SALESMAN | | | PACKAGI | NG | |
| d 2 | Hiled Hygi other ent, ti | Be C | 17. Father's Name (First, Middle, Last) | | | 8. Mother's Name (First | , Middle, Maide | | ivu . | |
| ılan | should be filed withind Mental Hygiene. marked other than matic event, the M | To B | HARRY | KILBER | G | KATIE | | POLA | NSKY | |
| Maryland | 2 sho and 1 Is ma | | 19a. Informant's Name/Relationship (Type. Print) | | - | d Number or Rural Rou | | | | |
| | 1 and Health Im 27 | | ELEANOR KILBERG / WIFE 20a. Method of Disposition | 20b. Place of Disp | | #313, BALT | | | | |
| Baltimore, | Pariti L | | 1 Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify) | n State BALTIMORI | ematory or other place) E HEBREW | 02/20/2 | 008 RE | Location - City or T | WN, MD | |
| Bal | permit. Departr Importa | | 21. Signature of Funeral Service Littensee | ger | | TERSTOWN RO | AD - PI | N & BROS KESVILLE | | |
| | | | 23 . Part1. Enter the disease, or complications or shock, or heart failure. List only one cause in | | | | iratory arrest, | | Approximate Interval Between Onset and Death | |
| | Physician /Medical | | resulting in death) | d-stage Alak | imers 12en | mento a | | | | |
| | Examiner | | Due to | Due to (or as a consequence of): $ASCVD$ | | | | | | |
| 10 | erek. | Je. | Sequentially list conditions, if any, leading to minimulate cause. Enter Underlying Cause (Disease or injury | (or as a consequence of): | | | | | | |
| | nd A | Examiner | that initiated events | | | | | | | |
| 30, | oe exe cian a | E | resulting in death) Last Due to | o (or as a consequence of): | | | | | | |
| 68760, | ficate be executed physician and the burial-transit | edical | d | | | | | | | |
| O. Box | The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transit | Physician/Me | in the past 12 months? | gnant at time of death 5 | □Ectopic pregnancy □ Other (specify) | | | 23d. Date of delive Month | very Day Year | |
| Δ. | s that ned by deta | by Pr | Part II. Other significant conditions contributing to | death but not resulting in the t | underlying cause given | in Part I. 2 | 3e. Did tobacco | use contribute to | the cause of death? | |
| Vital Records, | w require been sig should b | | | | | | 1 Tes | 2 No 3 Pro | bably 4 Unknown | |
| မင္ပ | ne law requ has been ge 2 shoulk | plet | | | | 2 | 4a. Was an autopsy | | opsy findings available | |
| E B | The cate h | Completed | autopsy prior to completion of cause performed? 1 Yes 2 1 No 1 Yes 2 No | | | | | | | |
| Vita | Physician: The rthis certificate har ral director, page | Be | 25. Was case referred to medical examiner? Hospital: | | Othor | 26. Place of Death (Che | | | | |
| o | Phys ral di | -: To | 1 Les 2 140 | Inpatient 2 ER/Outpatie e of Injury 28b. Time of | IN 3LI DOA | 4 L Nursing Home | Residence | | ify) | |
| ion | nding Ph th. r: After th | tion | 1 | onth, Day Year) Injury | of 28c. Injury a Work? M 1 ☐ Ye | es 2□No | | y 000000 | | |
| Division | al or Atter after dea I Director d in by the | Certification: | 3 Suicide 6 Could not be 28e. Place | ce of injury - At home, farm, st ding, etc. (Specify) | treet, factory, office | | ocation (Street a ity or Town, Sta | and Number or Rui te) | ral Route Number, | |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune | Medical C | 29a. Certifier (Check only one) 1 Certifying Physician: To the 2 Medical Examiner: On the and ma | ne best of my knowledge, dea basis of examination and/or in nner stated. | th occurred at the time nvestigation, in my opi | e, date and place, and di nion, death occurred at | ue to the cause(the time, date a | s) and manner as nd place, and due | stated. to the cause(s) | |
| | Totl withi Totl | Mc | 29b. Signature and title of certifier MACHAGEMEND | | 29c. License r | 51165 | | ate signed (Month) | | |
| | 4 | | 30. Name and address of person who completed car N - Shark of Rajupakse | use of death (Item 23a) (Type, | Print) treet, Suite ? | 200, Reister | stown, 1 | MD 2113 | S 6. | |
| | Sta Registr | _ | 30. Name and address of person who completed can N. Share ~ Rejural Se. 31. Date filed (Month, Day, Year) FEB 2 1 2008 | Registrar's Signature | N. | | | | | |
| | | | I P I H T | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| 08-01418 |
|-------------|
| India Lewis |

| idia Lewis | F | - For State Registrar | | f Maryland / | | nent of cate of | | nd Mental H | | g. No. 200 | 08 0525 |
|--|-------------|--|--|--|-----------------|--------------------|--------------------------|-----------------------------------|--|---|--|
| Physiciai ledical Examin | | 1. Decedent's Name (First, | Middle,Last) | | 15 | 34/15 | 5 | | 2. Date of Deat Month February 1 | | 3. Time of Death 1728 hrs |
| | | 4a. Facility Name (if not ins | | | LE | W A | o. City, Town, o | or Location of Deat | | 4c. County of Dear | |
| | Ļ | 1800 Hollins Stree | et # 126 W | | /In case Insale | : | Baltimore | - IKU-4 OAL | | | IA |
| Funeral Director | | 5. Social Security Number 224-40-89 Usual Residence of Decede | 34 1_N | 1 2XIF | (In yrs. last b | Yrs. | If Under 1 Ye Months Da | | | Fore | rthplace (State or gn puntry) VIRGINIA |
| any | - | 10a. State 10b. Co | | 1 | 0c. City, Tow | n or Location | n | | | | 10d. Inside City Limits |
| Maryland 28a-f show | اةِ | MARYLAND | N/ | A | | | BA | LTIMO | | ITY | 1 Yes 2 No |
| ne Mary or 28a | Director | 10e. Street and Number | | 11 57 | 1 n=# | 101 | 10f. Zip Code | 0.22 | 7 | og. Citzen of What Cou | intry? |
| with the Maryland us 23a or 28a-f she be notified at once | | 1 0 0 0 A C | 1 | 12. Was Decedent E | ver in U.S. | | | メノメメ lispanic Origin? (S | | | rican Indian, Black, |
| r death | Funeral | 1 Never Married 2 | Married | | No No | | | an, Mexican, Puerto | Rican, etc.) | White, etc. | |
| urs afte tural", | 2 | Widowed 4 | 0 | Yes, Give Yeer r Dates: highest grade comp | leted) 16a | | res 2 X N | o specify: ation (Give kind of | work done | Specify: 5 | LACK |
| 6 172 hor an "na cal Ex | Completed | Elementary/Secondary (0 | | College (1-4 or 5+ | | during mos | st of working lif | e. DO NOT use ref | tired) | | docuy |
| 5-0036 Iled within 7 Hygiene. I other than | 틹 | 6 THGRAD 17. Father's Name (First, M | E ddle Last) | | | Hou | ISEF | EEPER | e (First, Middle, N | PRIVATE | HOMES |
| 21215. 21215. Mental Hy marked of | Be C | CHARL | F. | | THO | MAS | , | | PARET | naiden Surname) | LLERY |
| ∑ | ₽ | 19a, Informant's Name/Rela | tionship (Type | e, Print) | | | | eet and Number or | Rural Route Num | ber, City or Town, Stat | e, Zip Code) |
| - p = e e | | 20a. Method of Disposition | EVA | NS CNIE | | | on (Name of c | OCREST emetery, | Date Date | 20c. Location - City 6 | Town, State |
| imore Pages 1 nent of H ant: If i | | | ation 3 er Specify: | Removal from State | 1 | atory or othe | r place) CEME | TERU 11 | -23-08 | LANSDOU | WE MA |
| Baltimore, permit. Pages I ar Department of Her Important: If ite injury or other tr | 1 | 21. Signature of Funeral Se | |) 10 | 1 , | 22. Na | me and Addres | ss of Fallity BR | awN J | | AL HOME |
| Physician | - (| 23a. Part I. Enter the disease | e. or complica | Willed | ne death. Do | 102 | 140 N | . FULIOI | VAVE, | BALTO, M | D 2/2/7 Approximate Interval |
| /Medical | | failure. List only one c Immediate Cause (Final dis | ause on each | line. /pertensive Ath | | | | | or respiratory arro | or, orroom, or mount | Between Onset and Death |
| Examiner | | or condition resulting in dea | AL. | e to (or as a conseq | | | | | | | |
| | <u>ا</u> اِ | Sequentially list conditions, f any, leading to immediate | | e to (or as a conseq | uence of): | | | | | | |
| | 티 | cause. Enter Underlying Cause. Enter Underlying Cause or injury that initial events resulting in death). Let the content of th | ted C | e to (or as a conseq | uence of): | | | | | | |
| ecuted and transi | ᇍ | | d | | | | | | | | |
| 60, ate be ex hysician e burial | Medical | UNPENDED F FEMALE: | X A | #P.perME,g | 376, 2/2 | 21/08 T | Γ | | | | |
| cath certificate attending phy for use as the t | 2 au/[2 | 3b. Was decedent pregnan past 12 months? | in the | 23c. If yes, outcome 1 Live birth | | | death 3 | Ectopic pregn | ancy | 23d. Date of deliver Month | y Day Year |
| Box 687 death certific he attending p d for use as th | Physician/n | 1 Yes 2 No 9 | Unknown | Pregnant at tir Unknown | ne of death | 5 Othe | r (Specify) | | | | |
| Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi | y F | Part II. Other significant co | onditions co | entributing to death t | out not resulti | ng in the und | derlying cause | given in Part I. | 23e. Did tol | bacco use contribute to | the cause of death? |
| IS, P. C quires that en signed | | | | | | | | | // | 2 No 3 Pro | , ш |
| COFC | Completed | | | | | | | | 24a. Was a autops perform | sy prior to | utopsy findings available completion of cause of |
| | S _ | 5. Was case referred to me | dical | | | | 26.Plac | e of Death (Check | | No 1 Y | es 2 No |
| of Vital Records, ing Physician: The law requir Wher this certificate has been some director, page 2 should be a face of the control of the c | n o | examiner? | Hos | pital: 1 Inpatient | 2 ER/0 | Outpatient | | Other: | | Residence 6 🗸 Othe | r: Scene |
| Division of Vital Bospital or Attending Physician: 24 hours after death. Funeral Director: After this certifietely filled in by the funeral director. | :: ² | 7. Manner of Death 1 V Natural 5 | Pending | 28a. Date of Injury (Month, Day,Yea | r) 28b | . Time of Inju | · 1 _ : | ury at Work? Yes 2 No | 28d. Describe h | ow injury occurred | |
| Division pital or Attendii ours after death. eral Director: / | cat | 2 Accident | Investigation Could not be | 28e. Place of Injur | y - At home, | farm, street, | | | 28f. Location (S | treet and Number or Ri | ural Route Number, City |
| Diversal of filled i | | 4 Homicide | determined | (Specify) | | | | | or Town, St | | |
| D To the Hospital within 24 hours. To the Funeral completely filled | ealcai | one) 2 Medical | Examiner: Or an | | | | | | | e(s) and manner as sta and place, and due to the | |
| | ≥ 2 | 9b. Signature and title of ce | rtifier | | | | 29c. Licen | se number | | 29d. Date signed (Mo | |
| | 3 | 0. Name and address of pe | rson who com | pleted cause of dea | th (Item 23a) | | | | | February 19, 20 | JO |
| 5 | | Ana Rubio MD. | Assistant I | Medical Examir | , | | eet, Baltim | ore, MD 2120 | 1 | | |
| Stat Registra | _ | 1. Date filed (Month, Day, Y | ear) | 32. Redistrar's | Signature | Lon | elles. | | | | |
| | | - r t t | (| TILL TO SERVICE | | 13/1 | | | | | |

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MILDRED E. LARSEN Month Day Year Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death ANNE ARGUNDEL SALTIMORE WARHINGTON MEDICAL CENTERS KURNIE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Sept 4, 1 9. Birthplace (State or Foreign Days 217-05-9655 1 □ M 2 🕅 F Hours 91 1916 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Anne Arundel Pasadena Maryland 1 ☐ Yes 2X No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 249 Beach Road 21122 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 😿 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: 9 3 Nidowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Housewife & Mother 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Franz Ethel Hamann 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 249 Beach Rd., Pasadena, Md. Mildred L. Larsen (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem Pk. 4 □ Donation 5 □ Other (Specify) 2/16/08 Glen Burnie, MARYLAND 21. Signature of Funeral Service Licensee Kevin E Ecker 22. NMPCCOLOUS POTUNIAL Funeral Home, P.A. 3204 Mountain Rd., Pasadena, Md. 21122 23a. P.rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res, iratory are slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SUBDURAL disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1□Yes 2☑No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CORUNARY ARTERY DISEASE 1 Yes 2 No 3 Probably 4 Unknown Completed ETENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an DIABRIES MELLITUS 3 No 2 No 25. Was case referred to medical examiner?
1

→ Yes 2 No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Natural Injury 6.30PM 1 ☐ Yes 2 No BLACKED OUT AND 2 Accident MEBRUARY 11 2008 3 ☐ Suicide 6 □Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Home 249 BEACH ROAD (ASADENA MD 21122 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Wedical (Check only one) and manner stated.

Examiner Division or Vital Records, P.O. Box 68760, as t detached Funeral within 24 ho To the Fun completely

Funeral

Director

"natural", or items 23a or 28a-f shov idical Examiner must be notified at

with the Maryland

Maryland 21215-0036

Baltimore,

permit. Pages 1 and 2 should be Department of Health and Mental

Physician

/Medical

State Registrar 29b. Signature and title of certifie

Day, Year)

Drive

MD

Hospital

Registra's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Burnie MD

| DIVISION OF VITAL HECOTAS, P.O. BOX 68760, ~C. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at | |
|--|-----------------------------------|--|--|
| | or Vital Records, P.O. Box 68760, | s cer lirect | |

| | | For State | | State o | f Marylar | | artment <i>rtificate</i> | | | and M | 1ental H | | - 211 | 0.8 | 05 | 255 |
|--|----------------|---|-------------------------------|---|--|---------------------------------------|-----------------------------|----------------------|--------------------------|-----------------|------------------------------|---------------------------|---------------------|--------------------|-----------------------------|-------------|
| | | Registrar 1. Decedent's Nam | ne (First. Middl | e. Last) | | | incate | OI L | Jealii | | 2. Date of | | No. | 00 | 3. Time o | |
| Physici /Medic | | Issak | llich | Miransky | | | | | | | Month Feb. | 16, | Day 200 | Year 18 | 9:03 | A M |
| Examir | | 4a. Facility Name (| If not institution | n, give street and nu | mber) | | 4b. City, To | own, or | Location of | of Death | | | | y of Death | | |
| | + | | | Pike, Apt 1 | | | Silver | | | | | | Prince | Georg | es | |
| Funeral | | 5. Social Security N | | 6. Sex 1 X □ M 2 □ F | 7. Age (In yrs 61 | . last birthday) Yrs. | If Under 1 Months | Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of (Month, | Day, Yo | | 9. Birthp | lace (State ntry) | or Foreign |
| Director | | 218-47-0390 Usual Residence of | | | | 115. | | | | | Oct. 14 | , 19 | 946 | Belar | us | |
| /land ow at | | 10a. State | 10b. County | | 10c. C | ity, Town or Lo | cation | | | | | | | 1 | Od. Inside (| City Limits |
| Man 3-f sh filed | 햣 | Maryland | Prince | Georges | Sil | ver Spri | ng | | | | | | | | 1 □ Ye | 2 ☑ No |
| th the or 28; e not | Director | 10e. Street and Nu | mber | | | | 10f. Zip C | Code | | | | 10g | Citizen of | What Cour | ntry? | |
| 23a ust b | la I | 11700 01d | Columbia | Pike, Apt. | 116 | | 209 | 04 | | | | | USA | | | |
| er dea | Funeral | 11. Marital Status | | Armed Fo | | J.S. 13. | Was Decede f Yes, specif | nt of His y Cubar | spanic Ori n, Mexicar | gin? (Spo | ecify Yes or Rican, etc.) | No- | | ce - Americ | | |
| rs afte | by F | 1 ☐ Never Marr 3 ☐ Widowed | /\ | ied 1 ☐ Yes If Yes, Gi Year or D | ve^ | | 1 □ Yes 2 | No X | Specify: | | | | Speci | fy: | | |
| 2 hou | | | 15. Deceden | t's Education | 4.00. | 16a. Deced | lent's Usual | Occupa | tion | | | T 16 | b. Kind of E | Whi Business/In | | |
| hin 72 e. In "na Media | plet | Elementary/Seco | cify only highe | st grade completed) College (| 1-4or 5+) | (Give | kind of work DO NOT use | done di | uring mos | t of work | ing | | | | , | |
| y the | Completed | 12 | | Concgo (| . 401 01) | Housek | eeping | | | | | | Nursin | g Home | | |
| be file tal Hy d oth | Be (| 17. Father's Name | (First, Middle, | Last) | | | | | 18. Mothe | er's Name | (First, Midd | ile, Mai | den Surna | me) | | |
| ould Men narke | 은 | Elia Mira | | | | | | | | | anski | | | | | |
| 12sh hand 7 Isrr traum | | 19a. Informant's N | | | | | g Address (S | | | | | | • | | , | |
| 1 and Healt em 2 | | Irina Mirar 20a. Method of Disp | | vi re | 20b. | Place of Dispo | Dld Colu | | Pike | | 716, S | _ | r Spri | | _ | |
| ages ent of t: If it y or o | | 1 ☐ Burial 2 | Cremation | 3 ☐Removal from | State | cemetery, crer tropolit | natory or oth | er place | | /20/2 | | | xandri | • | | |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | | 4 □ Donation 21. Signature of Fy | | | | · · · · · · · · · · · · · · · · · · · | . Name and | | | | | | | | | |
| Per Sheri | | 1 | Vah | Mp123 | ,4 | | leck Fui 601 Sand | | | | | MD | 20707 | | | |
| No. | | 23a. Part1. Enter t | the disease, or | complications that conly one cause on e | au ed the dea | | | | | | | | | | Approxima Interval Be | ite |
| Physician | | Immediate Cause (| (Final | Only one cause on e | 7/70/A | alla | ande | AAA | ,10 | 200 | 82 | | | | Onset and | Death |
| /Medical | | resulting in death) | | Due to | or as a consec | quence of): | | VV | Jun | > LIL | | | | | | |
| Examiner | _ | Se juentially list co | onditions. | b. 4 | OGAC | cob | 556 | | | | | | | | | |
| ed sit | nine | if any, leading to in cause. Enter Unde Cause (Disease or | nmediate erlying injury | Due to | or as a consec | quence of): | | | | | | | | | | |
| execut and at-trar | Examine | that initiated events resulting in death) I | S | c | or as a consec | quence of): | | | | | | | | | | |
| cate be executed physician and the burial-transit | dical | | | d | | | | | | | | | | | | |
| tificat ig phy as the | ledi | | | u | | | | =: | | | | | 1 | | | |
| death certific attending p | an/N | IF FEMALE: 23b. Was deceden | | 23c. If yes, ou | come pf pregn | ancy | Ectopic pred | nancy | | | | | | ate of delive | ery | |
| e dea he att ied fo | sici | in the past 12 1 ☐ Yes 2 [| □No | | ant at time of | | Other (spec | | | | | - | M | onth | Day | Year |
| d by t | Physician/Me | 9 Unknown | | ons contributing to d | | ulting in the cur | doduine oou | oo obyo | a in Dod I | | 020 Di | م مامد ا | | A_11 | ne cause of | 4 |
| w requires that the d been signed by the should be detached | l by | ONU | UWO | | ani bui noi les | suiting in the th | idenying cau | ise givei | II III Fait I. | ' | | Yes | 2 □ No | | ably 4 | |
| v requ | etec | 71100 | <u> </u> | | | | | | | | / | | | | | |
| he lav e has ige 2 | Completed | H***** | | | | | | | | | 24a. Wa au pe | as an topsy rformex | . | | psy findings npletion of | |
| an: T tificati or, pa | | 25. Was case refer | rred to medica | | | <u>-</u> | | | 26 Place | of Dooth | 1 ☐ Yes | <u> </u> | No | | 2□ No | |
| ysicia is cer direct | To Be | examiner? | | Hospital [*] | npatient 2 | ER/Outpatien | t 3□ DOA | Othor | r· | rsing Ho | . / | | e 6 □Oti | her (Snecif | v) | |
| ng Ph ter th neral | Ë | 27. Manner of Deat | th 5 ∐ Pendin | 28a. Date | of Injury th, Day Year) | 28b. Time of Injury | 280 | c. Injury Work? | at | | 28d. Describ | | | , -, | 7) | |
| eath. or: A | atic | 2 Accident | investig | ation | | , , | М | | es 2 🗌 I | No | | | | | | |
| or At fter d Direct in by | Certification: | 3 ☐ Suicide 4 ☐ Homicide | determ | ined 28e. Place | of injury - At h ng, etc. <i>(Speci</i> | ome, farm, stre fy) | eet, factory, o | office | | | 28f. Location City or 1 | (Stree Town, S | t and Numi tate) | ber or Rura | l Route Nui | mber, |
| pital ours a eral I | | 29a. Certifier | 1X Cartifyin | g Physician: To the | heet of my kny | awledge death | occurred at | the time | o data an | d place | and due to t | | - (-) and | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | edical | (Check only one) | 2☐ Medical | Examiner: On the b | asis of examination as a stated. | ation and/or inv | estigation, in | n my op | inion, dea | th occuri | red at the tim | ne, date | and place, | , and due to | the cause | (s) |
| To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. | Me | 29b. Signature and | title of certifie | | | .15 | 29c. L | License | number | | | 29d. | Date signe | ed (Month, | Day, Year) | |
| 1 | | 112 | 2114 | (LL/M |) | CIM | P | 00 | 611 | 104 | 5 | | 2/10 | 7/0 | 3 | |
| V/ | | 30. Name and addr | ress of person | who completed caus | e of death (Iter | n 23a) (Type, | Print) | | | | 10 | | | - | | 200 |
| | | Mary | teles | - KUt U | H WI | 0 12 | 2018 | lur | - DV | Cla | 4Drs | bili | JW D | gre | MP | 40704 |
| Sta Registr | | 31. Date filed (Mon | FEB 2 | 1 2008 32 | egistrar's Sign | ature | and I | | | | | | | | ν | , |
| nogisti | 41 | | | es a | | | 1 | | | | | | | | | |

Box 68760 Division or Vital Records, P.O. To the Hospital or Attending Physician: within 24 hours at To the Funeral Completely filled i 1/2

Uds

Pherson

State Registrar

31. Date filed (Month, Day, Year) 2008 FEB 21

CUILLERHO JOSE

29b. Signature and title of certifier

OH, was grand see Environment

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301 HOSPITAL DRIVE, GLEH BURLIE, HD 20161 ODSADUAIS 2. Registrar's Signature

29c. License number

D0065+14

29d. Date signed (Month, Day, Year)

FEBRUARY 5, 2008

| | | | State of Maryland / Department of Health and I State Certificate of Death | - | giene _{Reg. No.} 2008 | 3 05257 |
|--------------|--|----------------|--|--|---|--|
| 9 | Physici | an | 1. Decedent's Name (First, Middle, Last) | 2. Date of De Month | _ Day Yea | 3. Time of Death |
| | /Medio | | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death | | 20 2009 4c. County of De | |
| | | | 783 Harmony Avenue Arno1d 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. | 8. Date of Bir | Anne An | |
| | Funeral Director | | 218-58-3797 1 M 2 T F 55 Yrs. Months Days Hours Min. | Oct 16 | | irthplace (State or Foreign Country) Aryland |
| | land ow | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits |
| | e Mary Ba-f sh rtifled | Director | Maryland Anne Arundel Arnold | | | 1 □ Yes 2X No |
| | with th | l Dire | 10e. Street and Number 783 Harmony Avenue 10f. Zip Code 21012 | | 10g. Citizen of What (| Country? |
| | r death ems 23 er mus | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes specify Cuban Mexican Puert | pecify Yes or No o Rican, etc.) | | |
| 50 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flee Z1 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Fu | 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 1 □ Yes 2 □ Ano Specify: Year or Dates: | , | | Mhite |
| 2-003p | 72 hou 'nature dical E | | 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of wor life. DO NOT use retired) | king | 16b. Kind of Busines | s/Industry |
| 7 | 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r traumatic event, the Med | Completed | Elementary/Secondary (0-12) College (1-4or 5+) Waitress | | Restauran | nt. |
| and | be filed tal Hyg d other event, | Be | 17. Father's Name (First, Middle, Last) 18. Mother's Name | | Maiden Surname) | |
| ıryıa | should nd Men marke matic | ည | Paul F. Braun 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Ru | y V. Koo | | Zin Code) |
| , <u>S</u> | and 2 sealth ar | | Mary V. Braun, Mother 783 Harmony Avenue Ar | | | |
| ore | ages 1 nt of He : If item | | 20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) | Date | 20c. Location - City of | |
| Saitimor | mit. Pa partmer cortant Injury | | | 20/08 | | e, Maryland |
| | Departing Department on the once. | | 21. Signature of Funeral Service Lightsee Thomas Gregori 22. Name and Address of Facility 23. Signature of Facility 23. Signature of Facility 24. Signature of Facility 25. Name and Address of Facility 26. Prederick Road | | | |
| 3 | Physician | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition | or respiratory a | rest, | Approximate Interval Between Onset and Death |
| | /Medical Examiner | | disease or condition resulting in death) a. Due to (or as a consequence of): | | | 1 Walth |
| | | ē | Sequentially list conditions, if any, leading to immediate cause. Fifter that thing Cause, (Disease or injury) | | | |
| | nd Aded | Examiner | that initiated events c. | | | |
| 00/00 | ificate be executed by physician and the burial-transit | EX BE | Due to (or as a consequence of): | | | |
| 00 | rtificate ng phys as the | Medical | IF FEMALE: | | | |
| ב ב | To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. After this certificate has i een signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | Physician/M | 23b. Was decedent pregnant in the past 12 months? | | 23d. Date of d Month | elivery Day Year |
| ; | of the d | hysic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown | | | |
| Į, | ires the signed | 2 | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | / | to the cause of death? Probably 4 □Unknown |
| COIUS, | s i een | Completed | | 24a. Was | | autopsy findings available |
| ב | The la | Som | | autor perfo 1∐ Yes | osy prior to rmed? death? 2 No 1 □ Ye | completion of cause of |
| אונם אונם | sican: certific irector, | Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: I Inpatient 2 I ER/Outpatient 3 DOA Other: 4 Nursing H | th (Check only o | ne) | |
| 5 | ng Phy fter this ineral d | on: To | 27. Manner of Death 1 | | dence 6 Other (Sp now injury occurred | ecity) |
| 200 | ottendi death. ctor: A y the fu | icatio | 2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 280 Place of injury. At home farm street factory office | 28f Location (9 | Street and Number or I | Rural Route Number |
| 2 | tal or Ars after al Dire | Certification: | 4 Homicide determined building, etc. (Specify) | City or Tov | vn, State) | tural House Warnber, |
| | To the Hospital or Attending Physicen: stating 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, to | edical | 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated. | , and due to the irred at the time, | cause(s) and manner date and place, and d | as stated. ue to the cause(s) |
| | To the within To the comple | Me | 29b. Signature and title of certifier 29c. License number | | 29d. Date signed (Moi | |
| | | | Mo D652772 | | 2 20 2 | 009 |
| | H | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tacon 19/00 Bistgat Russing June 300 | Ann | pilis MD | 21401 |
| | Sta Registra | | 31. Date filed (Month, Day, Year) FEB 2 1 2008 22. Registrar's Signature | | • | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 200 Teburary Mbagwu Jiweze Juliet /Medical 4c. County of Death 4a. Facility Name, (If not institution, give street and number, Town, or Location of/Death Examiner dale Squar 8. Date of Birth (Month, Day, Year) 28 32 (In yrs. last birthday If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months 1□ M 2□ F Hours Director 75 Nigeria 633-09-3899 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Hanover MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Nigeria by Funeral 21076 6327 Patuxent Quarter Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 3 ☐ No Specify. Specify: 3 ₩ Widowed 4 Divorced Black "natural" Completed traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Public School Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maryland 212 Is marked other than System of Nigeria School Teacher 12th grade 4yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jenet Ozokpo Onyedinma Enchendu 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21076 f Health 6327 Patuxent Quarter Road, Hanover, permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr <u>Sunday Mbagwu-Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3/28/08 Mbagwu Compound Umuahia, Nigeria 21. 2 gnature of Funeral Service Licensee March F/H West derrall <u>300 Wabash Ave, Baltimore, Md</u> 21215 2 a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final sever **Physician** di vez e or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed stone attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2X No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No certificate has 1□ Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 3 ☐ DOA 2 1 Impatient 2 ER/Outpatient After this 27. Mapner of Death Date of Injury 28c 28d. Describe how injury occurred Certification: (Month, Day Year) Injury s after dea... al Director: Aftr 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Division or Vital Records, P.O. Box 68760,

Baltimore, I

State Registrar

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR Hay Banani 9000 Franklin S

Year

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Month Play 14 2008 **Physician** 3.30A M Walter Gordon Mears /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Butimore Washington Wedie Burnie alLenlen If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□F Hours 578-24-9505 Director 84 09-06-1923 VA Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2X No Directo Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1 Birch Avenue 21061 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other any injury or other I XYes 2∏ No f Yes, Give 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☒ No white Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Retail** Seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louise Crockett Mears ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Birch Ave; Glen Burnie, MD 21061 Mrs. Mae K. Mears 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 2-22-2008 | Glen Burnie, MD 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation M00918 Services; 1 2nd Ave SW; Glen Burnie, MD 21061 tru 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CONCESTIVE HEART /Medical Due to (or as a consequence of): Examiner ZIXOMYOTATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed HADMIC and Due to (or as a consequence of): physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

Division or Vital Records, P.O. Box 68760,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Certificate of Death

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Registrar

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31. Date filed (Month, Day, Year)

32 egistrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** AM Metzger 7:15 2008 Howard /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Bultimore City Mercy Medical Center If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** 214-26-8343 78 Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10h Count 10c. City, Town or Location 10d. Inside City Limits is marked other then "netural", or items 23s or 28e-f ehow sumstic event, the Medical Exerdirer must be notified at tyTyYes 2 □ No Director Baltimore Marvland n/a 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 1510 Boyle Street 21230 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces?
1 ☐ Yes 2 ☒ No 14. Race - American Indian, permit. Pages 1 and 2 should be filled within 72 hours after of Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "netural", or Item any njury or other traumatic event, the Medical Exertifications. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Specify. δ White 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Glass Company Bottle Maker n/a 7 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Williamson Charles Metzger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1526 Boyle St. Baltimore, MD 21230 Margaret Thomas (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-19-2008 Brooklyn Park, MD Cedar Hill Cemetery 21. Signal La of Funeral Service Licensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home Wayne Osterling 130 E. Fort Ave. Baltimore, MD Approximate Interval Between Onset and Death disea, e, or complications that caused a hine List only one cause on each line nock, or heart in or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Imm of the Cause (Final disease or condition resulting in death) Physician days Respiratory Failure secondan /Medical Due to (or as a consequence of): Examiner 25 do Emplema Sequentially list on offices if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ed by the attending physicien and detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown cate hes been signed by t pege 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 X No 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death Check only one Hospital: 1 Inpatient 1 Yes 2 No Other. 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide within 24 hours a To the Funerel L ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number eronica Linales 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Place Baltimore MD 21202 Jeronica 31. Date filed (Month, Day, Year) FEB 2 1 2008 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 18 **Physician** 2008 Ε MANN 12:15A [™] RUTH /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HARFORD BEL AIR HEALTH & REHABILITATION CTR. BEL AIR If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 09/25/1923 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours 1 □ M 2 X F MD 84 218-14-6052 Director Usual Residence of Decedent be filed within 72 hours after death with the Maryland ntal Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ıral", or items 23a or 28a-f show I Examiner must be notifled at 1 ☐ Yes 2 No Director HARFORD BEL AIR MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA SCOTTSDALE DRIVE 21015 1311 G Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married WHITE 1 ☐ Yes 2 🛣 No 3altimore, Maryland 21215-0036 Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MEDICAL SECRETARY MEDICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental h and Mental BROWNSTEIN KATES REBECCA LOUIS ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SCOTTSDALE DRIVE, BEL AIR, MD 21015 Health i JEFFREY MANN / SON other 1 20b. Place of Disposition (Name of cemeters), cremeters of African MEMORIAL PARK Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important; If it any Injury or o once. 1 Burial 2 □ Cremation 3 □ Removal from State 02/20/2008 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee REISTERSTOWN ROAD - PIKESVILLE, MD 21208 8900 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final week **Physician** disease or condition resulting in death) /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Physician/Medical Examiner and 3 or Attending Physician: The law requires that the death certificate be executed the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions/contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 9 20 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an certificate has autopsy perform funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 VNo 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi e and addres person who completed cause of death 308 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0.5Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 26 02 200 /Medical cility Nar (If not institution, give street ity. Town. or Location of Death 4c. County of Death Examiner 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex last birthday) 8. Date of Birth **Funeral** -22-2 Months Days Min 1 □ M 2 🖫 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10b. County **Gity Limits** Items 23a or 28a-f show iner must be notified at 1 Yes 2 No Director eet and Number 10g. Citizen of What Country? 10f. Zip Code 21216 S Completed by Funeral . Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No o lf Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Item 27 is marked other than "natural", or Item other traumatic event, the Mudical Examiner is Black, White, etc. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: X 3 DWidowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify pnly highest grade completed) Give kind of work done during most of working life. DO NOT use retired) 20 1t condary (0-12) College (1-4or 5+) Name (First, Middle, Last) (First Middle, Maiden Sur To Be 19b. Mailing Address (Street and Number or ral Route Number, City or Town, State, Zip Code) 204 Place of Disposition (Name of 20c Location - City or Town, State Method of Disposition Department of H Important: If Ite any Injury or ot Burial 2 Cremation 3 ☐Removal from State 4 Donathon 5 DOthei Specify) 21 Signature art1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each ed the death. line. Do not enter the mode of o Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical sequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as the burial-tran and / the death certificate be exec Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) 9□Unknown 9 Unknown Port II. Other significant conditions contributing to deathybut not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 □ No 3 robably 1 ☐ Yes 4 □Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No certificate has autopsy performe 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; g 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ၉ 1 Dupatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier t 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) title of certifier

State Registrar 30. Name and addr

31. Date filed (Month, Day, Year)

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(Type, Print)

r's Signature

08-01179 Kenneth Ness

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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| Physician/ | 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death | n |
| Medical Examine | Kenneth J. Ness 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death | |
| | Union Memorial Hospital Baltimore | |
| Funeral | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1f Under 1 Year f Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Marylam) 1.2 F 5.0 1.5 F 5. | and |
| Director | 213-58-1156 1X M 2 F 50 Yrs. March 8,1957 Country) | |
| / any | 10a. State 10b. County 10c. City, Town or Location 10d. Inside City | |
| e Maryland or 28a-f show lied at once. | MD Baltimore 1 X Yes 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? | No |
| e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Titem 27 is marked other than "natural", or items 23a or 28a-f short traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2561 Miles Avenue 21211 USA | |
| r death with to or items 23a . must be not | | ζ, |
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| 5-0036 led within 72 hours after litygiene. other than "natural", the Medical Examiner Completed by | Elementary/Secondary (0-12) College (1-4 or 5+) | |
| 5-00; ed with tygiene other t | 12 Plumber Pvt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) | |
| 1215 d be fill ental H arrked | George E. Ness Rose Ohle | |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica To Be Comple | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19 Briarwood Road Shrewsbury, PA 17361 | |
| re, MC 1 and 2 sl F Health an f item 27 | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 1 Burial 2 Cremation 3 Removal from State crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State | |
| imo Pages ment ol tant: I | 4 X Donation 5 Other Specific Howard University 2/16/08 Washington, DC | 3 |
| Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum. | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Austin ROyster Funeral F 3821 14th Street, NW, Washington, DC 200 | |
| Physician | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate I Between Ons | Interval |
| /Medical xaminer | Immediate Cause (Final disease a. Heroin intoxication | |
| | or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b. | |
| niner | if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Chapter or shifter that initiated | |
| ted Insit | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | |
| | | |
| b. Box 68760, the death certificate be executed to the attending physician and ched for use as the burial - Irr. Physician/Medical | IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery Anoth Day Yes | |
| Box 687 e death certifice the attending p ed for use as th | 2.50. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Ye 4 Pregnant at time of death 5 Other (Specify) | ar |
|). Boy the death by the att ached for Physi | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death but not resulting in the underlying cause given in Part I. | ath? |
| Division of Vital Records, P.O. B rat or Attending Physician: The law requires that the d its after death. al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached artification: To Be Completed by Physicians | 1 Yes 2 No 3 Probably 4 ✔ Unk | |
| Records, I The law requires fricate has been sig page 2 should be Completed | 24a. Was an 24b. Were autopsy findings a autopsy prior to completion of cau | |
| Recc The lav icate ha | | No |
| Vital Recystrian: The his certificate director, page | 25. Was case referred to medical 26.Place of Death (Check only one) | - |
| n of Vi ding Physi After this funeral dir | 1 Ves 2 No Tipo of Injury 1 28c Injury at Work2 28d Describe how injury occurred | |
| sion ttendir death ctor: A y the fu | 1 Natural 5 Pending 2/10/2008 2:55 pm 1 Yes 2 X No unk | |
| Division or spital or Atending spital or Atending rours after death neral Director: After filled in by the fune Certification: | 3 Suicide 6 X Could not be 4 Homicide Could not be 4 Homicide Attended Homicide Specify) found in a residence 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number of Town, State) 2602 Hamden Ave. Baltimore, MD | er, City |
| Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the ledical Certification | | |
| To the How within 24 h To the Fur completely | one) 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) | |
| 2 | O.C.M.E. February 11, 2008 | |
| | 30. Name and address of person who completed cause of death (Item 23a) | |
| | Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 | |
| State Registra | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | 1 - State Registrar | | - | rtificate of | | | | 8 | 05 | 265 |
|---|--|-------------------------------|---|--|---|---|--|---------------------------------------|--|--------------------------------|---------------------------------------|------------------------|
| | Physici /Medic | | Decedent's Name (First, Middle, Robert | Martin | Pr | itchett | | 2. Date of Dea Month Februar | Day | Year 08 | 3. Time o | of Death P M |
| | Examin | | 4a. Facility Name (If not institution, Gilchrist Cente | | | 4b. City, Town, o | or Location of Deat | | 4c. County o | | | |
| Ç | Funeral Director | | | | n yrs. last birthday) 68 Yrs. | If Under 1 Year Months Days | | | h T | | ace (State | or Foreign |
| should be filed within 72 hours after death with the Maryland | Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Completed by Funeral Director | Usual Residence of Decedent 10a. State 10b. County Maryland Baltin 10e. Street and Number 3417 Yorkway 11. Marital Status 1 Never Married 3 Widowed 4 Divorced (Specify only highest Elementary/Secondary (0-12) | 12. Was Decedent Eve Armed Forces? 1 □ Yes 2X No If Yes, Give Year or Dates: Education grade completed) College (1-4or 5+) | r in U.S. 13. | Mas Decedent of Lif Yes, specify Cub. In Yes X No dent's Usual Occup. It is not not not not not not not not not not | Hispanic Origin? (S ban, Mexican, Puer Specify: pation during most of wo | Specify Yes or No- to Rican, etc.) | 10g. Citizen of WI U.S.A. 14. Race Black Specify: 16b. Kind of Bus Bethlehe | - America , White, e Whi | an Indian, etc. | City Limits s 2₺ No |
| Vialia A | Mental Hygie Irked other I Itic event, th | To Be Co | 12 years 17. Father's Name (First, Middle, L Benjamin Woodro | , | Cont | ract Neg | 18. Mother's Na | me (First, Middle, Agnes Fi | Maiden Surname | | .eer | |
| e, Mary | Health and hem 27 is mather trauma | | 19a. Informant's Name/Relationsh Tina Schott | Daughter | 6400 | corkley | Road, Ros | sedale, N | | 212 | 237 | |
| Dallillor Dermit, Pages | tment of h tant: If ite jury or ot | | 20a. Method of Disposition 1 Burial 2XCremation 4 Donation 5 Other (Sp | ecify) | 20b. Place of Dispo cemetery, cre Bayview C | rematory | 23, | 2000 | Baltimore | Cit | |). |
| | Depai Impor any ir | | 21 Signature of Funeral Service L | Connel | KU 17 | onnerly 110 soll | ers Point | Road, I | Dundalk, | | | |
| E | nysician Medical xaminer | ner | 23a. Part1. Enter the disease of shock, or heart failure. It is of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | -a. Anglosa | onsequence of): | ter the mode of dyi | ing, such as cardia | c or respiratory ar | rest, | V | Approxima Interval Be Onset and | Death |
| rtificate be executed | ig physician and as the burial-transit | dical Examiner | Cause (Disease or injury that initiated events resulting in death) Last | cDue to (or as a co | onsequence of): | | | | | | | |
| The law requires that the death certif | been signed by the attending should be detached for use as | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. if yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown | ☐Fetal death 3[| ⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _ | _Э у | | 23d. Date Mon | | ry Day | Year |
| v requires that | en signed b | by | Part II. Other significant condition | ns contributing to death but n | ot resulting in the u | ınderlying cause gi | ven in Part I. | 23e. Did to | obacco use contri | | e cause of ably 4 | |
| The law r | cate has be , page 2 shr | Completed | | | | | | 24a. Was autop perfo 1 Yes | osy pi rmęd _i ? de | ior to con eath? | osy findings npletion of a | available cause of |
| VII. | sertif | Be | 25. Was case referred to medical examiner? | Hoepital: | | l Ott | | ath (Check only o | b # | | | - |
| D Phys | fter this on the direction of the direct | on: To | 1 ☐ Yes 2 📉 No 27. Manner of Death 1 🛣 Natural 5 ☐ Pending | Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Yo | 2 ER/Outpatie 28b. Time of Injury | III JU DOA | | Home 5 ☐ Resid | dence 6 Othe now injury occurre | | nos | pile |
| DIVISION I or Attending | within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 on the funeral director, page 2 on the funeral director. | Certification: | 1 Natural 5 Pending 2 Accident investigs 3 Suicide 6 Could ne 4 Homicide determine | ation | - At home, farm, st | M 1□ | Yes 2 No | 28f. Location (S City or Tow | Street and Numbe vn, State) | r or Rura | l Route Nui | mber, |
| ne Hospita | n 24 hours ne Funeral oletely filled | Medical C | | Physician: To the best of n xaminer: On the basis of ex and manner stated | amination and/or in | | | | | | | (s) |
| To th | Withi To tl | Ž | 29b. Signature and title of certifier | | | 1 | se number | | 29d. Date signed | | Day, Year) | |

State Registrar WD 6701

N Charles ST TOUSON MO 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 05266 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death February 19, 2008 Physician Carol Ann Peters 1:27 A. M /Medical 4a. Facility Name (If not institution, give street and number)
Good Samaritan Hospital 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🙀 F Months Days Hours 61 218-46-1645 Director July 21,1946 Maryland Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits show 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at N/A Baltimore 1 Yes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6517 Sefton Avenue U.S.A. 21214 Funeral 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 👿 No Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 yr's Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Craig Rydzewski ပ္ Chester Marie Jet, Mè.

"ermit. Pages I and 2 shc.
Department of Health and M.
Important: If item 27 iany Injury or n.** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, MD 21214 Albert J. Peters - Husband 6517 Sefton Ave 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Sacred Heart of Jesus Feb. 22,2008 Baltimore, MD 22. Name and Address of Facility Leonard J. Ruck 5305 Harford Road 21. Signature of Funeral Service Licenses Inc. Baltimore Maryland 21214 Handook 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one on the card line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (ollas a consequence of): 2 week disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if an enter Underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed Congestive burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) the 9□Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 2 ☐ No 1∐ Yes Physician: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 hpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 1 Natural Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 5 ☐ Pending investigation Hospital or Attending Injury 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funeral I 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the ž 1 29b. Signature and title of 29d. Date signed (Month, Day, Year) ٥ 50. Name and address of person who completed cause of death (Item 23a) (Type, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2 1 2008 FEB Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:35PM Clarence 02 2008 /Medical 4a, Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore RAdums Cowley Shocke Tra MC If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year_ 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 ☐ F Months Days Hours Min 219 03-18-1920 Director naryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City. Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐Yes 2 No Director Saltimore NSOF 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21204 venue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ρ 3 X Widowed 4 ☐ Divorced white Completed item 27 is marked other than "natur other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) United States Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 arrier permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyd.
Important: If item 27 is marked any injury or other any injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Heinbuch larence Katherine Kamsburg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 515 Park Avenue Towson MD 21204 Holene Hatch - Daughter 20b. Place of Disposition (Name of cometery, crematory or other place).

Morel and Memoral 2/22/08 Baltimore, Maryland

22. Name and Address of Facility

Evans Funeral Chapel+ Cremation Services - arkuille

8500 Harfard Road Parkuille MD 21234 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Z Stacie Martin Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirating an est, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Erter the Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 2 □ No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been signated by the state of t Completed 24b. Were autopsy findings avallable prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an page 2 s autopsy performed? Yes 2 No certificate has 1□ Yes Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? 1 Yes 2 No 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 은 1 Inpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Medical Certification: Hospital or Attending Injury 1 Natural 5 Pending Fall at home Feb 14200 5:50 AM 1 ☐ Yes 2 Mo investigation after death. 2 X Accident within 24 hours efter dearh To the Funeral Director: completely filled in by the 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Ö σ. Records, or Vital Division

> Registrar DHMH 17 Rev 1/2001

State

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Thomas Grisson

FEB 2 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Ba Himsee

D006074

515 Park Ave

29d. Date signed (Month, Day, Year)

ome

22 S. Greene St

32 Registrar's Signature

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 2 1 2008

Ksharma Garg

31. Date filed (Month, Day, Year)

Silver Spring, Maryland 20910

| | | | For State | State of Ma | ryland | | | | | and M | ental | | 2.0 | 108 | 05276 |
|---------------------|---|----------------|---|--|-----------------------------------|-------------------------------|------------------------------------|------------------------------|--------------------------------|-------------|--------------------------|--|-------------|---------------------------|---|
| | | 7 | Registrar 1. Decedent's Name (First, Middle, La | ctl | | Cei | rtificat | e or L | Jeatn | | 2. Date o | | No. C | 100 | 3. Time of Death |
| | Physici | | | , | ouis | 7.0 | | D: | ave | | Month O2 | | Day 8 2 | Year 1008 | 6:30p. M |
| 120 | /Medic Examin | | Mildred 4a. Facility Name (If not institution, given | | Out | 5 e | 4b. City, | | Location o | of Death | 02 | | 4c. Count | | |
| | | - | Liberty Health | | | | | | timo | | | | | | |
| | Funeral Director | | 5. Social Security Number 6. S 368–12–3251 | Sex 7. Age | 97 | ast birthday) Yrs. | If Under Months | r 1 Year Days | If Under a | Min. | 8. Date o (Month | , Day, Ye | ar) 10 | 9. Birth Cos | nplace (State or Foreign untry) AL |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | , Town or Lo | cation | | | | | | | | 10d. Inside City Limits |
| | Maryl-f sho | tor | MD NA | | Ва | altim | ore | | | | | | | | 1 Yes 2 No |
| | h the or 28a or notif | Director | 10e. Street and Number | | | | 10f. Zip | p Code | | | | 10g. | Citizen of | What Co | untry? |
| | 23a c ust be | | 2813 Oswego Av | e | | | | | 1215 | | | | | S.A. | |
| 36 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Married ★□ Widowed 4 □ Divorced | 12. Was Decedent E Armed Forces? 1 Tyes 2 No. If Yes, Give Year or Dates: | | | Was Dece If Yes, spe 1 □ Yes | | spanic Orion, Mexicar Specify: | | cify Yes o Rican, etc | r No- .) | | ck, White | |
| 3 | 2 hour | ed b | 15. Decedent's E | ducation | I | 16a. Dece | dent's Usu | ıal Occupa | ation | | | 16b | . Kind of E | | Black |
| Maryland 21215-0036 | within 72 iene. than "na the Medic | Completed | (Specify only highest grade) Elementary/Secondary (0-12) 12th grade | ade completed) College (1-4or 5 na | +) | | kind of wo DO NOT u louse | | luring mosi) e | t of workir | ng | | Нс | me | |
| andz | d be filed intal Hygi ed other event, t | Be | 17. Father's Name (First, Middle, Last Pasco Hughley |) | | | | | | | (First, Mi | | den Surna | me) | |
| 3 | should nd Me mark mark | 2 | 19a. Informant's Name/Relationship | Type. Print) | | 19b. Mailir | ng Addres | s (Street a | and Numbe | er or Rura | l Route N | umber, Ci | ity or Towi | n, State, Z | (ip Code) |
| Ĕ | and 2 saith a 27 is | | Mildred Allen | -Niece | | | | | Ave | , Ba | alti | more | , Mc | 21 | 215 |
| Baltimore, | of He | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ | Removal from State | 20b. Pl | ace of Dispo emetery, crea | osition (Na matory or | me of other plac | e) | D | ate | | | , | Town, State |
| Ē | : Pag tment tant: | | 4 ☐ Donation 5 ☐ Other (Speci | fy) | De | troit | | | | | /08 | W | arre | en, | Michigan |
| Ra | permit Depar Impor any in | | 21. Signature of Funeral Service Lice | - Le lec | | 43 | 300 r | Waba | s of Facilit Wes sh A | ve, | | | | Md | 21215 |
| | | | 23a. Part 1. Enter the disease, or conshock, or heart failure. List only | plications that caused one cause on each lir | the death ne. | . Do not en | ter the mo | de of dying | g, such as | cardiac o | r respirato | ory arrest, | | | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | - u. | | diac | arr | y-the n | nies | | | | | | 15 minney |
| | Examiner | | | Due to (or as | | ience of): clearor | 10 | heom | r d | 1 sear | 0 | | | | 10 4 25 |
| ŀ, | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as | | | | | | | - | | | | |
| | cate be executed physician and the burial-transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c. Due to (or as | perl | nsion | | | | | | 4. | | | 2045 |
| 8/60, | be exe | al E | resulting in death, East | Due to (or as | a consequ | ence of): | heor | or J | failur | e | | | | | 5 448 |
| 789 | icate physi s the t | dical | | d | | | | | | | | | | | |
| P.O. Box | The law requires that the death certific tte has been signed by the attending p bage 2 should be detached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | 2 Fetal | death 3 | ⊒Ectopic p ⊒ Other <i>(s</i> | | | | | _ | | ate of deli Ionth | ivery Day Year |
| 7 O | ires that the de signed by the a be detached f | Phy | 9 ☐ Unknown Part II. Other significant conditions | | it not rock | Iting in the u | ndorlying | cause aive | on in Port I | | 230 | Did tobac | CO USA CO | atribute to | the cause of death? |
| ords, | w requires the been signed should be d | by | Dementa, | penipheral | | - | | - | | | | | 2□ No | | |
| Vital Hecords, | Physician: The law r r this certificate has be ral director, page 2 sh | Completed | | | | | | | | | | Was an autopsy performed es 2 🕏 | 13/ | . Were au prior to death? | topsy findings available completion of cause of 2 DNo |
| <u>E</u> | | Be C | 25. Was case referred to medical examiner? | | | | | | 26. Place | of Death | (Check c | | | | |
| | hysic this ce | 2 | 1 Yes 2 No | Hospital: 1 ☐ Inpatie | | ER/Outpatie | | | 4 L I Nu | | | | e 6 □O | | cify) |
| DIVISION OF | ath. or: After | ation: | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation | | ry Y Year) | 28b. Time of Injury | M | 28c. Injury Work 1 ☐ ` | yat ⟨? Yes 2 ☐ | | 28d. Desc | ribe how i | injury occi | irred | |
| DIVIS | al or Atte s after de nl Directo ed in by th | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | | ury - At ho c. <i>(Specify</i> | me, farm, st | reet, factor | ry, office | | 2 | | ion (Stree r Town, S | | nber or Ru | ural Route Number, |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, to | Medical (| | hysician: To the best of miner: On the basis of and manner sta | f examinat | | | | | | | | | | |
| | To th withir To th comp | Me | 29b. Signature and title of certifier | / | | | 29 | oc. License | e number | - | | | _ | | h, Day, Year) |
| } | < | | | | | | | 1230 | 494 | | | | 2/20 | 1200 | - 8 |
| , | 3 | | 30. Name and address of person who | 716 maicle | o ch | cree le | one. | suite | 302 | - co | atons. | ville | mo | ×12. | 18 |
| | Sta Registi | | 31. Date filed (Month, Day, Year) FEB 2 1 20 | Registra | ar's Signa | ture | W/S | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 052 Certificate of Death Reg. No. 🐔 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 9 39 PM **Physician** Month **JENNIFER ROBERTS** 2008 MOSS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore ROSE dale If Under 1 Year | If Under 24 Hrs. Square 16! Sex HOS PI + Al 7. Age (In yrs. last birthday) trantlin 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours 1 □ M 2 💢 F 090-44-1348 56 NY Director 01/29/1952 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 1 ☐ Yes 2 No Director MD HOWARD COLUMBIA 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code must be r 5678 STEVEN FOREST ROAD, #70 21045 USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. Specify: WHITE ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) LEASING CONSULTANT GRADY MANAGEMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LARRY MOSS **ELEANOR** GOLDSTEIN ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5678 STEVEN FOREST ROAD, #70, COLUMBIA, RANDEE KLATSKY / PARTNER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 02/20/2008 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Immediate Cause (Final disease or condition resulting in death) Fail We **Physician** spirator /Medical Due to (or as a consequence 1): Examiner Adult Respiratory Distress Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed neu monia Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an was a... autopsy performed? Ves 20 No cate has by page 2 s certificate 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: 1 Appatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ို After th funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Cath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Lacl

31. Date filed (Month, Day, Year)
FEB 2 1

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Franklin Square Drive Baltimore, MD 2/237

9000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

middle

ton

For

Physicia /Medic Examin

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at annee.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

| | Registrar | | | | | Ce | rtifica | te of l | Death | | | Reg. N | lo. C | UU | U | 1616 | | | | |
|-------------------------------|---|-----------------------|-----------------|-----------------------|--------------------------------------|---|---------------------------|----------------------|-------------------|------------|--------------------------------|--------------|---------------|------------|---------------------------------------|-------------|--|--|--|--|
| | 1. Decedent's Name | e (First, Midd | lle, Last) | | | | | | | | 2. Date of D | | | | 3. Time | of Death | | | | |
| n | Damia Ca | anhio (| Sudano | | | | | | | | Feb 17 | 7. Ž | 008 | Year | 6:00 | m a | | | | |
| al - | Doris So 4a. Facility Name (I | | | and num | her) | | 4h City | Town or | Location | of Death | 100 1. | | lc. County | of Death | 1000 | F | | | | |
| er | , , | | | | 061) | | | | | oi Deatii | | | Balti | | | | | | | |
| 2 | 5309 Pal | | | | | | | te Ma | ITSII If Under | 24 Hrs | 8. Date of B | | Daiti | | | | | | | |
| | 5. Social Security N | lumber | 6. Sex 1 | | '. Age (In yrs. I | | | Days | Hours | Min. | (Month, D | ay, Yea | | 9. Birth | Birthplace (State or Foreign Country) | | | | | |
| | 214-20-0 | 0487 | 10 101 2 | | 83 | Yrs. | | | | | 06-23- | -192 | 924 MD | | | | | | | |
| | Usual Residence of | | | | 1 | | | | | | | | | | | | | | | |
| . | 10a. State | 10b. County | / | | 10c. City | , Town or Lo | ocation | | | | | | | | 10d. Inside | | | | | |
| اق | MD | Balti | more | | Wh | ite Ma | arsh | | | | | | | | 1 □ Y∈ | s 2 No | | | | |
| <u>e</u> | 10e. Street and Nur | | | | | | 10f. Z | ip Code | | | | 10g. C | Citizen of W | hat Cou | ntry? | | | | | |
| ۃ | 5000 D-1 | 1 | Chanasa | _ | | | 2.1 | 162 | | | | US | ۸ | | | | | | | |
| a a | 5309 Pa | Tomino | | | lent Ever in U. | 2 10 | | | inu natio Ou | daino (Co. | asif. Van au N | | | Amorio | can Indian, | | | | | |
| Ĭ. | 11. Marital Status | | Aı | med Ford | es? | 5. 13. | If Yes, sp | ecify Cuba | an, Mexica | n, Puerto | ecify Yes or N Rican, etc.) | 0- | | , White, | | | | | | |
| Ē | 1 Never Marr | | lf i | ∐ Yes 2 Yes, Give |) | | 1 ☐ Yes | 2 ™ No | Specify: | | | | Specify: | | | | | | | |
| 9 | 3 X Widowed | 4 Divorced | d Ye | ear or Dat | les: | | | | | | | | | Whi | ite | | | | | |
| ě | (Spec | 15. Deceder | nt's Education | pleted) | | 16a. Dece | kind of w | ork done i | durina mos | st of work | ina | 16b. | Kind of Bu | siness/In | dustry | | | | | |
| Completed by Funeral Director | Elementary/Seco | | | ollege (1- | 4or 5+) | life. | DO NOT | use retired | 1) | | 9 | | | | | | | | | |
| 0 | 12 | , , , | | | , | Homer | naker | | | | | 0 |)wn Ho | me | | | | | | |
| Be | 17. Father's Name | (First, Middle | , Last) | | | | | | 18. Moth | er's Name | e (First, Middl | e, Maide | en Surnam | e) | | | | | | |
| 10 B | Elmer J | . Crea | mer | | | | | | Jos | ephi | ne Sur | de1 | | | | | | | | |
| Ĕ | 19a. Informant's Na | ame/Pelation | chin (Time P | rint) | | 10h Maili | na Addres | s (Street | | | al Route Num | | v or Town | State Zir | n Codel | | | | | |
| | Brian J | | | nn) | | | • | , | no St | | | | rsh M | | , | | | | | |
| - 1 | | | | | 1001 0 | 1 | | | | | | - | | | | | | | | |
| | 20a. Method of Disp 1 Burial 2 | | 2 Domos | al from S | 20b. P | lace of Disperent of the lace | osition (Na ematory or | ame of other plac | :e) | ı | Date | 20c. | Location - | City or T | own, State | | | | | |
| | 4 ☐ Donation | | | ai iroin S | | Lawn | Мане | 2 | c | 12-22 | 2008 | Ba. | ltimo | re M | D | | | | | |
| ı | 21. Signature of Fu | uneral Service | e Licensee | | · Jour | | | | ss of Facili | | himune | | | | | C - | | | | |
| | t | Acr. | 10 | 12. | Va Pa | Δ | | | r Rd | 50 | tingha | | MD 21 | | ine III | | | | | |
| - | 23a. Part1. Enter t | the disease of | r complication | on that on | upped the death | | | | | | | | .ID 21. | 230 | Approxim | ate | | | | |
| | shock, or hea | art failure. Lis | st only one cau | use on ea | ch line. | | | | _ | | | | | | Interval B | Between | | | | |
| i | Immediate Cause (| | 0 | icat | TC MY | OCA. | ROI. | AL | INF | PAR | C7/01 | J | | 12 | JWK. | NOWN | | | | |
| | resulting in death) | | a | Due to (c | r as a consequ | uence of): | | | | | | | | _ | 7 | - | | | | |
| | | | | OR | ENAR | 9 4 | RTC | FR 4 | . 10 | rse | AJC | | | | 400 | 75 | | | | |
| ē | Sequentially list co if any, leading to in cause. Enter Under | nditions, nmediate | | | r as a consequ | | | | | | | | | - | | | | | | |
| 듣 | Cause (Disease or | iniurv | < | AC | CVD | 7 | | | | | | | | | 4 PM | - 1 | | | | |
| xan | that initiated events resulting in death) | S | c | Due to (c | r as a consequ | ience of): | | - | | | | | | _ | 100 | 1 / | | | | |
| 쁘 | | | | Ta 6 | 2 7- | 0 | MO | 11 | hee | | | | | | 400 | 7/5 | | | | |
| /Medical Examiner | | | d | 110 | | .0. | | | • • • • | | | | | | / | - | | | | |
| Nec | IF FEMALE: | | | | | | | | | 1.4 | | | | | | | | | | |
| | 23b. Was deceden | nt pregnant | | | ome pf pregna rth 2 □ Feta | | ⊒Ectopic | nregnancs | | IA | | | 23d. Date | | - | | | | | |
| <u>i</u> | in the past 12 1 ☐ Yes 2 | months? | 4 | □Pregna | int at time of d | | Other (| | | | | | Moi | nth | Day | Year | | | | |
| ys | 9 ☐ Unknown | | 9 | Unkno | wn | | | | | | | | | /0 | ~ T | | | | | |
| <u>a</u> | Part II. Other signi | ficant condit | tions contribut | ing to dea | ath but not resu | ulting in the u | underlying | cause giv | en in Part | l. | 23e. Did | tobacc | o use contr | ibute to t | the cause o | f death? | | | | |
| Completed by Physiciar | Hu | 2007 | EASS | nN | STA | SE | + | | | | 1 [| Yes | 2 X No | 3□ Pro | bably 4[| □Unknown | | | | |
| te l | | | | | | | | | | | | , , , , | 4.110 | 0 | | | | | | |
| 음 | 04 | SIPI | dem | ca | | | | | | | 24a. Wa | s an opsy | 24b. V | Vere aut | opsy finding | s available | | | | |
| E | | | | | | | | | | | per | formed' | ? | leath? | 2□ No | NA | | | | |
| O | 25. Was case refer | rred to medic | al | | | | | | oe Place | o of Dogs | 1 Yes h (Check only | | 100 | | 2 140 | 7411 | | | | |
| ∞ ∣ | examiner? | | Hospit | al: | | ED/Outrotic | -1 000 | Oth | or: | | 4.0 | | | | | | | | | |
| ₽ | 1 Yes 2 | | | | patient 2 | 28b. Time | | /UA | 4 ⊔ N | ursing Ho | me 5 Re | | | , , | ify) | | | | | |
| <u>:</u> | Manner of Deat Natural | ın 5 ⊟ Pendi | | a. Date o (Month | n, Day Year) | Injury | | 28c. Injur Wor | | 7 | 28d. Describ | JA | ijury occurr | ea | | | | | | |
| ä | 2 Accident | | tigation | NI | 4 | NA | М | 1 🗆 | Yes 2□ |]No | | V/7 | | | | | | | | |
| Ĕ I | 3 ☐ Suicide 4 ☐ Homicide | 6 □ Could deteri | mined 28 | e. Place o | of injury - At ho g, etc. (Specif | | | ry, office | | | 28f. Location | (Street | and Number | er or Rur | al Route N | umber, | | | | |
| Medical Certification: To | | | | | J. 1-1 | _ | JA | | | | , , | , 5 | MA | | | | | | | |
| <u>ا ۾</u> | 29a. Certifier | | | | best of my kno | | | | | | | | | | | | | | | |
| o O | (Check only one) | 2 Medica | | On the ba and mann | sis of examina er stated. | tion and/or i | nvestigatio | on, in my o | ppinion, de | ath occur | red at the tim | e, date | and place, | and due | to the caus | e(s) | | | | |
| Me | 29b. Signature and | title of certifi | | | | | 2 | 9c. Licens | e number | | | 29d. [| Date signed | (Month | , Day, Year |) | | | | |
| | | | ع | 0.~ | 20 | ago. | | | 0176 | 79 | | | 2/20 | | | | | | | |
| | 7 150 | 1023 | ~ | | | | | NO | 0116 | >// | | | 21 40 | 1 5 | ··· | | | | | |
| Ì | 30. Name and add | | | ted cause | of death (Item | 23a) (Type | , Print) | 1- 1 |) - | | 7/ | | | | | | | | | |
| | | | R Ro | / | BOCTI | more | 13 | TO | 2 | 12 | 16 | | | | | | | | | |
| е | 31. Date filed (Mon | nth, Day, Year | r) | 32. Re | of death (Item Bo (†/ | ture | GARA | (t) | | | | | | | | | | | | |
| ar | | FFR | 7. 1 ZU | JO N | 1 | 50 1 | | | | | | | | | | | | | | |

Sta Registr

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|--------------|-----|--|
| 8-01 | 400 | |

Herbert Leroy Sealover, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

| erbert Leroy S | ealc | otato of maryland / B | epartment of Certificate of | | d Mental H | | 200 g. No. | 8 05273 |
|---|----------------|--|--|---------------------------------|---|---|--------------------------------------|--|
| Physici edical Exami | | Decedent's Name (First, Middle,Last) Herbert Leroy | Seal | lover | Jr. | 2. Date of Death Month February 1 | Day Year 9, 2008 | 3. Time of Death 1928 hrs |
| | | 4a. Facility Name (if not institution, give street and number) 3428 Court Way | | 4b. City, Town, or Dundalk | Location of Death | | 4c. County of Death Baltimore Cou | |
| Funeral Director | | 5. Social Security Number 6. Sex 7. Age (in y | yrs. last birthday) 57 Yrs. | Months Day | | 7 | h(MM/DD/YYYY) 9. Bi Forei | |
| Ow any | | | City, Town or Locati | | | | | 10d. Inside City Limits 1 Yes 2 X No |
| ith the Maryland 23a or 28a-f show any notified at once. | Director | Maryland Baltimore 10e. Street and Number | Dunda | 10f. Zip Code | | 10 | g. Citizen of What Cou | intry? |
| with the M ns 23a or be notified | | 3428 Courtway 11. Marital Status 12. Was Decedent Ever | | | spanic Origin? (Sp | | | • rican Indian, Black, |
| after death 'al'', or iten iner must l | by Funeral | 1 Never Married 2 Married Armed Forces? 1 Yes 2 1 3 Widowed 4 Divorced If Yes, Give Year or Dates: | No | es, specify Cuba | n, Mexican, Puerto specify: | Rican, etc.) | White, etc. Specify: Whi | |
| 36 in 72 hours han "natur lical Exam | eted | 15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+) | during m | ost of working life | ation (Give kind of v e. DO NOT use reti | | 16b. Kind of Business | |
| 21215-0036 Mold be filed within 72 hours after a filed within 14 hours after a marked other than "natural", e event, the Medical Examiner. | Be Comple | 10 years 17. Father's Name (First, Middle, Last) Herbert Leroy Sealover Sr. | Mair | ntenance | 18.Mother's Name Mary Sho | | Funeral Ho | me |
| MD 212 rd 2 should be ulth and Ment m 27 is mark | ToB | 19a. Informant's Name/Relationship (Type, Print) Preston C. Sealover Brother | | • | | Rural Route Num | ber, City or Town, State | e, Zip Code) |
| Baltimore, MD 21215-0036 Degrnit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Helant and Mental Hygient in "natural", or items 23a or 28a-f she important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once | | 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State | 20b. Place of Dispos crematory or oth Moreland N | ition (Name of ce her place) | rebi | Date Cuary | 20c. Location - City o | r Town, State |
| Baltimore, permit. Pages I an Department of Hea Important: If iter | | 4 Donation 5 Other Specify: 1. Sunature of Funeral Service License e | 22. N | lame and Addres | s of Facility Funeral I | Home Of | Dundalk,P. Dundalk,MD | A. |
| Physician /Medical `xaminer | | 23d. Part I. Enter the disease or complications that caused the of failure. List only one cause on each line. Immediate Cause (Final disease a. Tramdo1, doxeptor condition resulting in death) Due to (or as a consequent | in, and alco | he mode of dying | , such as cardiac o | r respiratory arre | est, shock, or heart | Approximate Interval Between Onset and Death |
| | er | Sequentially list conditions, if any, leading to immediate Due to (or as a consequentially list conditions). | | | | | | |
| rted d ansit | Examine | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequent of the cons | nce of): | | | | | |
| 60, e be executed ysician and burial - transit | edical | X UNPENDED #50,27,28a-f | | 7 3/6/08 ' | TT | | | |
| Box 68760, e death certificate be exthe attending physiciar the attending physiciar ed for use as the burial | Physician/M | IF FEMALE: 23b. Was decedent pregnant In the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live birth 4 Pregnant at time 9 Unknown | 2 Fe | tal death 3 her (Specify) | Ectopic pregna | ancy | 23d. Date of delive Month | ry Day Year |
| s, P.O. B irres that the d signed by the | þ | Part II. Other significant conditions contributing to death but | not resulting in the u | underlying cause | given in Part I. | | bacco use contribute to | the cause of death? |
| ords v requ shoul | Completed | | | | | 24a. Was autop perfor 1 ✓ Yes | sy prior to med? death? | utopsy findings available completion of cause of |
| Division of Vital Recc To the Hospital or Attending Physician: The lar within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2 | To Be C | 25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient | | 3 DOA | | g Home 5 | Residence 6 🗸 Othe | er: Scene |
| Sion of Mending F death. ctor: After y the funer | | 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) Fnd 2/19/200 | | pm 1 | ury at Work? Yes 2 XNo | subject i | now injury occurred ngested drugs | |
| Division To the Hospital or Attence within 24 hours after death To the Funeral Director: | Certification: | 3 X Suicide 6 Could not be 4 Homicide 6 Could not be determined (Specify) home | | | | 3428° Cou | rt Way, DUnda | |
| To the He within 24 To the Fu | edical | one) 2 Medical Examiner: On the basis of examinat and manner stated. | | tion, in my opinio | n, death occurred a | | and place, and due to t | he cause(s) |
| | Σ | 29b. Signature and title of certifier Como Mincentina in | | 29c. Licen | se number .M.E. | | February 20, 20 | |
| 07 | | 30. Name and address of person who completed cause of death Donna M. Vincenti, MD Assistant Medical E | , | Penn Street | t, Baltimore, M | D 21201 | | |
| Si Regis | tate | 31. Date filed (Month Day, Yaar) 2008 32. Registrar's Si | grature | | | | | |

| | | - | For State | | State of M | laryland | - | irtment of I rtificate of | | | | giene | 008 | 05274 |
|----------|--|---------------------|---|---|---|--------------------------------------|--|---|------------------|-------------------------|----------------------------------|----------------------------|--|---|
| 6 | EJ. | | Registrar 1. Decedent's Nan | ne (First, Middle, La | ast) | | | | | | 2. Date of De | eath | Veer | 3. Time of Death |
| | Physicia /Medic | | CL | JATIS | Sco | TT | | | | | Month FEBRUA | KY 17 | Year 2008 | 3 1:50 PM |
| | Examin | er | , | | ve street and number |) | 0 | 4b. City, Town, | | | _ | 4c. C | ounty of Deat | h |
| | | | 5. Social Security I | | YVIEW ME | DKAL ge (In yrs. la | | If Under 1 Year | If Un | <i>MORE</i> der 24 Hrs. | I 8. Date of Bir | th | 9. Birl | hplace (State or Foreign |
| | Funeral Director | | 218-42- | | 1 → M 2 □ F | 60 | Yrs. | Months Days | Hou | rs Min. | 06-25- | 4 7 | Co | MD MD |
| | pı | | Usual Residence | of Decedent | | 100 Cib | , Town or Lo | oation | | | <u>'</u> | | | 10d. Inside City Limits |
| | larylar show | 5 | 10a. State | 10b. County BALT | MORE | Too. Oity | | NDALK | | | | | | 1 ☐¥Yes 2 ☐ No |
| | the M 28a-f notifie | rect | 10e. Street and Nu | | TIOKL | | DU | 10f. Zip Code | | | | 10g. Citize | n of What Co | ountry? |
| | h with | | 8023 NO | RRIS ROAI |) | | | 212 | 22 | | | U | SA | |
| 20 | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | by Funeral Director | | rried 2□ Married | 12. Was Deceden Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates | ? X IO | | Was Decedent of f Yes, specify Cul 1 ☐ Yes 2 2 X No | | | ecify Yes or No Rican, etc.) | | I. Race - Ame Black, Whit Specify: BL | e, etc. |
| 20 | "natura | Completed | (Spe | 15. Decedent's E ecify only highest gi | Education rade completed) | | 16a. Dece (Give | lent's Usual Occu kind of work done DO NOT use retire | pation during | most of work | king | 16b. Kind | of Business | Industry |
| 7 | withir iene. than the Me | duo | Elementary/Sec 12 | condary (0-12) | College (1-4o | 5+) | | ORER | Juj | | | | MOVIN | G |
| 2 | other other | BeC | | e (First, Middle, Las | it) | | 11/21/ | VIOL | 18. M | lother's Nam | e (First, Middle | , Maiden S | | <u> </u> |
| <u>a</u> | Menta Menta arked atic ev | 2 | RICHARD | SCOT | T | | | | | | RUTH MO | | | |
| ā | 2 sho and is ma | | | Name/Relationship | | वचा १२० | | ng Address (Stree | | | | | | |
| ב ע | Health tem 27 i | | 20a. Method of Dis | | M.D./BRO | | 1 | 1 RTDGEW esition (Name of matory or other plants) | | _ | Date Date | | ation - City or | |
| 5 | Pages nent of I int: If ite | | 1 ☐ Burial 2 | | □Removal from Stat | e | | natory or other pl Cremator | | 02-2 | 20-08 | Ralti | more, | MD |
| Dallillo | permit. Pages 1 am Department of Heal Important: If item 2 any injury or other once. | | 21. Signature of F | Funeral Service Lice | ensee | | | 2. Name and Add | ess of F | acility JAM | ES A. N | ORTON | | IS F.H. INC |
| | 452 % 0 | | 23a. Part1. Enter | r the disease, or coreart failure. List onl | mplications that caus y one cause on each | ed the death | n. Do not ent | 1701 LAU er the mode of dy | | | | | | Approximate Interval Between |
| | Physician /Medical | | Immediate Cause disease or conditi resulting in death | e (Final ion | 0. | EUM | 2 NIA | | | | | | | Onset and Death |
| | Examiner | | | | 1. | FLUE | | | | | | | | 10 DAYS |
| | B X # | iner | Sequentially list of any, leading to it cause. Enter Union | immediate derlying | Due to (or a | s a consequ | uence of): | | | | | | | |
| , in | al-tran | Examiner | Cause (Disease of that initiated even resulting in death) | nts) Last | c. Due to (or a | s a consequ | uence of): | | | | | | | LEAZ |
| 0/00, | ficate be executed physician and stree burial-transit | dical | | | d | | | | | | | | | |
| D | ertifica ing ph | Med | IF FEMALE: | | | | | | | | | | | |
| O. DOX | The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as | Physician/Me | 23b. Was decede in the past 1 1 Yes 2 9 Unknow | I2 months? 2 ☐ No | 23c. If yes, outcon 1□Live birth 4□Pregnant 9□Unknown | 2 ☐ Feta at time of d | ideath 3[| □Ectopic pregnan □ Other <i>(specify)</i> | су | | | 23 | 3d. Date of de Month | livery Day Year |
| ŗ | that the post of t | | Part II. Other sign | nificant conditions | contributing to death | but not resu | ulting in the u | nderlying cause g | iven in P | art I. | 23e. Did | tobacco us | e contribute t | o the cause of death? |
| ecords, | quires en sign uld be | ed by | END | STAG | E RENA | L D | SEAS | E | | | 1 🗆 | Yes 2□ | No 3∏P | robably 4 Unknown |
| Ē | ding Physician: The law requires that the death certif n. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as | Completed | | | | | | | | | 24a. Wa: auto per 1 Yes | opsy formed? | 24b. Were a prior to death? | utopsy findings available completion of cause of s 2 No |
| N I C | ician: Sertific ector, | Be | 25. Was case refeexaminer? | | Hospital: | | | | ther: | | th (Check only | | | |
| 5 | Phys r this ral dir | -T | 1 ☐ Yes 2☐ 27. Manner of De | No | Hospital: 1 Inpa | | ER/Outpatie | IL SEL DOA | 4 L | Nursing H | ome 5 ☐ Res 28d. Describe | | | ecify) |
| 201 | nding th. : After e fune | tion | 1 Natural 2 Accident | 5 ☐ Pending | (Month, I | Day Year) | Injury | f 28c. In W M 1 | orƙ? ⊒ Yes | 2 □ No | | . , | | |
| 2 2 2 | or Atter after dea Director in by the | Certification: | 3 ☐ Suicide 4 ☐ Homicide | 6 ☐ Could not | | njury - At ho etc. <i>(Specif</i> | ome, farm, st | reet, factory, offic | В | | | (Street and own, State) | Number or F | Bural Route Number, |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, I | Medical Co | 29a. Certifier (Check only one) | | Physician: To the be aminer: On the basis and manner | of examina | | | | | | | | |
| | To the vithin To the Comple | Me | 29b. Signature ar | nd title of cortifier | | | | 29c. Lice | | | | | | oth, Day, Year) |
| | | | 1 | X | h | | | RE | 3 - | 000 | , | Fes. | RUARY | 17,2008 |
| | 2 | | 30. Name and ad | | o completed cause o | f death (Iten | n 23a) (Туре, Е АЅТ <i>Е</i> | Print) ERN AV | ENU | e B | ALTIM | ORF | mb | 21224 |
| | Sta | ite | 31. Date filed (Mo | onth, Day, Year) | 32 Regi | strar's Signa | ature | ask 2 | | | | | | |
| | Registr | ar | 1 | FEB 2 1 2 | 2008 | News Sus | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar amend 27 per Dr. g876 2/21 fortific region Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2:25 PM GITL 2008 aby /Medical 4c. County of Death or Location of Death 4a. Facility Name (If not institution) give street and number) Examiner redical Center Baltimore 18rc) Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Birthplace (State or Forei Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 💢 F 2008 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 Yes 2 No a or 28a-f sh Baltimore Director paltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UST 23a 21224 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2/2 No Specify. 9 Blac 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic event, the Medical I be filed within ntal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) /A N 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked of 0 ဥ Pages 1 and 2 should Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trat Baltimore, MD Smith 138 N Belnord mother 20b. Place of Disposition (Name of cemetery, grematory or other pla Date Location - City or Town, State 20a. Method of Disposition Cole Man 20c 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fund 22. Name and Address FULLERY HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1□Yes 2 No Month Vear 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) the Division or Vital Records, P.O. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an page 2 s has autopsy ≰erformed? certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA ٩ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 5 Pending
Investigation 1X Natural 1 Yes 2 No 2 Accident ould not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 THomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of dentifier 2008 D63461 30. Name and address of person who completed cause of death (Item 23a) (Type, Print South Greene Stred Ballimore exan

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

B 2

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 10:30 P M <u>Schneider</u> February 20 2008 /Medical Norman August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7954 Eastdale East Point Baltimore Road If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 ☐ M 2 ☐ F Director 78 July 1 1929 Maryland 212-26-7703 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hyglene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercity once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Director Baltimore East Point Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7954 Eastdale Road U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Yes 2 No Specify. <u>م</u> Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Sign Painter Convery Sign Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Schneider Lillian Hoffman ပ August 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7954 Eastdale Road Baltimore, Maryland 21224 Martha Schneider (Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) February Bayview Crematory Inc. 22, 2008 Baltimore, Maryland 22. Name and Address of Facility W. Dabrowski/Chojnacki Funeral Homes P.A. ast 1005 Dundalk Ave. Baltimore, Maryland 21224 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Colon Cancer Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical SE been signed by the attending should be detached for use as IF FEMALE 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 T Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ¥☐Unknown Ulcer 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2□ No To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 2 No 2 ER/Outpatient 3□ DOA 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Tccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year)

State Registrar 1)eborah L

31. Date filed (Month, Day, FEB 2

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Holabird

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Year)

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Are BAIRMOY

February 21, 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Vear 2/01/08 Day **Physician** 8:45 AM RICHIE STEPHENS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda, MD Montgomery (In yrs. last birthday) 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/07/23 5. Social Security Number **Funeral** Days 1□M 2X1F Villa Vista Yrs 205-20-4820 Director Usual Residence of Decedent Georgia 10c. City, Town or Location 10d. Inside City Limits the Maryland 10a. State 10h County Pages 1 and 2 should be filed within 72 hours after death with the Maryiar nent of Health and Mental Hyglene.
In: If item 27 is marked other than "natural", or items 23a or 28a-f show mit: If item 27 is marked other than "natural", or items 19a notifiled at my or other traumatte event, the Medical Examiner must be notifiled at my or other traumatte. 1 XYes 2 No Director Silver Spring MD Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20910 USA 507 Schovler Road by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Tes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2XNo Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Industry 9th Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilbur Milner Nellie Owens ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 507 Schuyler Road, Silver Spring, MD 20910 Brenda Stephens/Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 2/06/08 Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐Donation 5☐Other (Specify) HU College/Med Washington, DC 22. Name and Address of Facility Austin Royster Funeral Home 21. Signature of Funeral Service Licens 3821 - 14th St., N.W., Wash., DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rean failure. List only one cause on such line.

Immediate Course (Final three diseases) androvascular rteriosclerotic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 4 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and rely filled in by the interest director, page 2 should be detached for use as the burlar-transit rely filled in by the funeral director, page 2 should be detached for use as the burlar-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) 9₩Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 4 ☑Unknown 1 Yes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of cortifier 30. Name and agricess of person who completed cause of death (Item 23a) (Type, Print)

State

-1-08

Old Georgetown Kol

Bethesda

Rathstein

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31. Date filed (Month, Day, Year)

8600

3. Registrar's Signature

George Robert Sullins

| Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | 2008 | 05278 |
|---|------|-------|
| Certificate of Death Reg. No. | | |

| | | 1- For State Registrar | | Ce | ertificate | of | Death |) | | | | Reg. No | D. | | | |
|---|--|---|-------------------------------|-----------------------------|----------------------------|---------|------------------------|------------|-------------------|-------------|-----------|----------------------|---|------------|--------------|----------------------------|
| Physicia | ian/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Apply | | | | | | | | | | | | | | |
| ledical Examin | | George Robert | | | | | | | | | Februa | | | | 0845 l | ırs |
| | | 4a. Facility Name (if not institution | - | umber) | | 4 | b. City, To | | ocation of | f Death | | | c. County o | of Death | | |
| _ | | 2200 Wilkens Avenue Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYYY) 9. Birthg | | | | | | | | | | | | | | |
| Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In yrs. | | y) | If Unde | _ | If Under Hours | Adim | | | | Cou | intry) | |
| Director | | 217-46-1639 | 1X M 2 F | | 63 | Yrs. | | | | | Nov | 28, | 1944 | Ma | rýlan | d |
| A | | Usual Residence of Decedent 10a. State 10b. County | | Inc. Cit | y, Town or L | ocatio | 20 | | | | | | | | 10d Inside | City Limits |
| w any | | | | 100.01 | | | | | | | | | | | | 2 No |
| Maryland 28a-f show | ctor | MD | | | Ba1t | . 1m | | | | | | T40- 0 | | -10 | | 2 |
| Mary r 28n | Direc | 10e. Street and Number 2200 Wilkens A | Vivoniio | | | | 10f. Zip | | 1223 | | | 10g. C | itizen of Wh US | | try? | |
| th the Maryland 23a or 28a-f sho notified at once. | - 1 | | | | , | | _ | | | | | | | | | |
| th wi | Funeral | 11. Marital Status 1 Never Married 2 M | 12. Was De larried Armed F | ecedent Ever in Forces? | U.S. 13 | | Deceder es, specify | | | | | | 14. Race White | | an Indian, | Black, |
| or dea | ᆵ | | 1 Yes | 2 X No | | | Yes 2 | 7 No. | | | | | Specify: | h | ite | |
| rs after | ۾ | 15. Decedent's Education (Spe | or Dates: | | | | 's Usual (| | | ind of wo | rk done | 16h | Kind of Bu | | | |
| 2 hou "nati | Ę | Elementary/Secondary (0-12) | | (1-4 or 5+) | | | st of work | | | | | | | 0111000711 | laccay | |
| 136 hin 7, e. dical | Complet | 10 | | 0 | sa | ani | tati | on w | orkei | r | | В | altim | ore | Count | v |
| 5-0036 iled within 7 Hygiene. I other than the M. dica | 탉 | 17. Father's Name (First, Middle | , Last) | | | | | | | | irst, Mid | | n Surname | | | <i></i> |
| 215 oe file ntal H | B | Howard Sulling | S | | | | | | Jul: | ia Re | eede | 2 | | | | |
| MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-fahmatic event, the Medical Examiner must be notified at once | | 19a. Informant's Name/Relations | ship (Type, Print) | | 19b. M | ailing | Address | (Street | and Numi | ber or Ru | ral Route | Number, | City or Tow | n, State, | Zip Code) | |
| MD id 2 sho llth and m 27 is aumati | | Lucinda Colema | an/sister | | 311 | L W | i11i: | s St | reet | Camb | orida | ge, M | D 21 | 613 | | |
| | | 20a. Method of Disposition | | | . Place of Di crematory | | | e of ceme | etery, | - | Date | 200 | . Location - | City or | Town, State | j |
| Baltimore, permit. Pages I ar Department of He Important: If ite | | 1 Burial 2 Cremation | | rom State | | | | rci. | | 2/2 | n / ns | S TAT | achir | na+ | n F |)C |
| Baltin permit. P Departme Importan injury or | + | 4 X Donation 5 Other S 21. Signature of Funeral Service | Licensee | 110 | waru | 22. N | ame and | Address of | of Facility | Aus | tin | Rov | ster | Fur | neral | OC Home |
| E Per E | | (Tro | (2) | × | | 382 | 21 1 | 4th | Str | eet | , NW | , Was | hingt | on, | DC | 2001 |
| Physician | ₹ | 23a. Part I. Enter the disease, or failure. List only one cause | complications that | caused the deat | tn. Do not er | iter th | e mode o | dying, s | uch as ca | ardiac or r | espirator | y arrest, s | hock, or hea | art | Approxim | nate Interval Onset and |
| /Medical | 1 | Immediate Cause (Final disease | A th a so a a la | erotic Cardio | vascular | Dise | ease | | | | | | | | | eath |
| Examiner | | or condition resulting in death) | | a consequence | | | | | | | | | | | | |
| 1 1 | | Sequentially list conditions, | b | | | | | | | | | | | | | |
| | mine | if any, leading to immediate cause. Enter Underlying Cause | | a consequence | OT): | | | | | | | | | | | |
| | Exan | (Disease or injury that initiated events resulting in death) Last | Due to (or as | a consequence | of): | | | | _ | | | | | | | |
| 3760, ficate be executed g physician and sthe burial - transi | | | d | | | | | | | | | | | | | |
| 760, cate be execut physician and ille burial - tra | edical | UNPENDED | AMENDED | | | | | | | | | | | | | |
| ficate be g physici | ΣΙ | IF FEMALE: 23b. Was decedent pregnant in the | | , outcome of pre | | | | | Te | 12-0.003 | | 2 | 3d. Date of | | | V |
| 68 certif | sician | past 12 months? | Live | pirth Inant at time of c | | | al death | | Ectopic | pregnand | у | 1 | Month | L | ay | Year |
| Box 687 ne death certific the attending ped for use as the | ysic | 1 Yes 2 No 9 Un | known g Unkr | | 5 | _ Otn | er (Spec | | | | | - 1 | | | | |
| that the deetached | | Part II. Other significant condit | tions contributing | to death but not | resulting in | the ur | nderlying | cause giv | en in Par | rt I. | 23e. l | Did tobacc | o use contri | bute to | he cause of | f death? |
| res that the signed by | ğ | | | | | | | | | | 1 | Yes 2 | No 3 | Prob | ably 4 🗸 | Unknown |
| ords, w requir | Completed | | | | | | | | | | | Vas an | | | | gs available |
| COT law has l | ם | | | | | | | | | | | autopsy performed | ? . | eath? | ompletion o | |
| Re The ficate | Ŝ | 25 11/ | | | | | | C Diana | of Death (| Chast. an | | res 2 ✓ | No 1 | Ye | s 2 | No |
| Vital Recystician: The Infection of the | Be | 25. Was case referred to medica examiner? | Hospital: | Inpatient 2 | ER/Outpa | tiont | | 10 | of Death (| Nursing | | Pacin | dence 6 | Other | Scane | |
| of V Phys er thi | 의 | 1 Yes 2 No 27. Manner of Death | | e of Injury | 28b. Time | | | | at Work? | | | | njury occurr | _ | . Scene | |
| n of Anding Ph | <u>ë</u> | 1 Natural 5 Pen | (Mont | th, Day,Year) | | | ,, | | es 2 | - 1 | | | , | | | |
| Sior Attend r death ector: by the | cat | 2 Accident Inve | stigation | ce of Injury - At | home farm | stree | t factory | office bu | ilding etc | 2 | 8f Locat | on (Street | and Numbe | er or Ru | al Route N | umber, City |
| Division of Vital Records, plut or Attending Physician: The law requirement after death. Irea Director: After this certificate has been stilled in by the funeral director, page 2 should be | ertification: | dete | id not be sermined (Specify | | none, ram, | 31100 | t, ractory, | onice bu | ilding, etc | " [* | | wn, State) | ana Homb |), O, I(G) | ai riodio i | arribor, Orty |
| Tospit 1 hour 1 uner: | O t | 4 Homicide 29a. Certifier 1 Certifying P | hysician: To the be | | ndre death | occur | ed at the | time date | e and plac | ce and d | ue to the | cause(s) a | and manner | as state | ed. | |
| Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certiful 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as | edical | one) 2 Medical Exa | miner: On the basis | of examination | and/or inves | stigati | on, in my | opinion, | death occ | curred at t | he time, | date and p | lace, and d | ue to the | e cause(s) | |
| 7. wii | ğ | 29b. Signature and title of certific | and mapner | stated. | | | 29c. | License | number | | | 290 | I. Date sign | ed (Mor | th, Day, Yea | ar) |
| O.C.M.E. Febru | | | | | | | | bruary 1 | 3, 200 | 8 | | | | | | |
| | - | 30. Name and address of person | who completed cau | use of death (Ite | em 23a) | | | | | | | | | | | |
| | | David Fowler M.D. | Chief Medical I | Examiner | 111 Pen | n St | reet, Ba | Itimore | e, MD 2 | 1201 | | | | | | |
| Sta | _ | 31. Date filed (Month, Day, Year) | 2000 32. F | Registrar's Signa | ature | a All | · A | | | · | | | - | | | |
| Regist | धा | FEB 2 1 | 4000 A | Barre State | 600 | 1963 | | | | | | | | | | |

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|-----------|--|----------------|--|---|-----------------|--|---------------------------------------|---------------------------------------|---------------------------------------|------------------------------|------------------------------------|------------------------|
| | Disconini | | 1. Decedent's Name (First, Middle, Last | () | | | | | 2. Date of De Month | eth Day | Year 3. T | ime of Death |
| · Har | Physici /Medio | | Josep | h S | mit | h | | | 02 | 18 | 1 30 | dopm |
| | Examir | ner | 4e Fecility Name (If not institution, give | | | | Dire | · | Location of Death | 4c. County | | 1- |
| | | | 5. Social Security Number 6. Se | | me al | | ff Under 1 Year | If Under 24 Hr | s. 8. Date of Bird | | | /A |
| | Funeral Director | | | x 7. Age | 75 | | Months Days | Hours Mir | . (Month, Da | y, Year) | | State or Foreign |
| | | | Usuel Residence of Decedent | | /5 | | | | 11-11-1 | 932 | Maryla | nd |
| | how # | | 10a. Stete 10b. County | | 10c. City, To | own or Loca | ition | | | | 10d. In: | side City Limits |
| | e Ma | Ş | Maryland N/ | A | |] | Baltimor | e | | | * | Yes 2□No |
| | 후 2 k | Director | 10e. Street end Number | | | | 10f. Zip Code | | | 10g. Citizen of V | Vhat Country? | |
| | 72 hours effer death with the Maryland natural', or Herne 23s or 28s-f ahow lical Examines must be notified at | ā | | Avenue | | | | 21211 | | 1.7.8 | USA | |
| | Per de | Funerai | 11. Marital Stetus ★★Never Married 2 Married | 12. Was Decedent E Armed Forces? | | 13. Wa | as Decedent of H res, specify Cuba | ispanic Origin? (an, Mexican, Pue | Specify Yes or No rto Rican, etc.) | Blac | e - American Ind k, White, etc. | ian, |
| 20 | rs eff | by | 3 Widowed 4 Divorced | 1 ☐ Yes — 3√5√N If Yes, Give Year or Dates: | .0 | 1[| Yes XXNo | Specify: | | Specify | wh: | ite |
| Š | natural', | 8 | 15. Decedent's Edu | ucation | 16 | Sa. Decede | nt's Usual Occup | ation | | 16b. Kind of Bu | siness/Industry | |
| | _ 3 | pie | (Specify only highest grad Elementary/Secondary (0-12) | fe completed) College (1-4or 5- | +) | (Give ki life. DC | nd of work done of NOT use retired | during most of w d) | orking | | | |
| | 7 2 4 4 | Completed | N/A | | | | N/A | | | N/A | | |
| nd | be filed tel Hyg d other event, | Be | 17. Father's Neme (First, Middle, Last) | | | | | | ame (First, Middle, | | Θ) | |
| Z a | Men Men arke | P | Bernard Smith | | | | | | adys Hook | | | |
| Maryland | C1 40 50 62 | | 19a. Informent's Name/Relationship (T) Charles Smith | ype, Print) Brother | | | | | Rural Route Numb | | | |
| | f Heelth tem 27 other tr | | 20a. Method of Disposition | promer | | | Ash Stre | | Ltimore, | | d 2121 City or Town, SI | |
| ğ | Pagas nant of I nt: If ite iry or o | | 1 ☐ Burial XXCremation 3 ☐ F | | | | ion (Name of tory or other place | ce) | 1 | | | |
| | ortant Prijury | - 1 | 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Libens | | Metro | | natory | ss of Facility | 2/20/200 | | nsville | , MD |
| Ba | pemit. F Depertm Importar any Injur | | Chan Al | uput | | Bi | irgee-He 31 Fall | nss-Seit s Road | z Funera Baltimor | l Home, e, Mary | Inc. land 212 | 211 |
| | | | 23a. Part1. Enter the disease, or composhock, or heart failure. List only o | lications hat caused | the death. D | | | | | | Appre | oximate ral Between |
| | Physician | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | 0 | | | | Onse | t and Death |
| | /Medical Examiner | | Immediate Cause (Final disease or condition | a. A | Deno | In | 1,2 | nome | 0. | | | |
| | | _ | resulting in death) | | Due to (or as | , | | 0 . | | * | | |
| | ted nsit | 듄 | | b. Chm | | 38th C | | our | none | brose | N | |
| <u>,</u> | axacu n and ial-tra | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | L | Oue to (or as | a conseque | ence of): | | | | | |
| 68760, | icate ba axecuted physiclan and s the bunal-transit | edical | that initiated events | c | Due to (or as | a conseque | ince of): | dali | | | | |
| | | | resulting in death) Last | CAs | 001. | (| | Foul | | | i | |
| Box | daath cerlifi le attending ed for usa as | Physician/M | | d | 18 m | < 1. | 1000 | 1 - 0 - 1 | | | 1 | |
| E | a daa he att | Sici | Part II. Other significent conditions cor | ntributing to death but | t not resulting | g in the und | erlying cause giv | en in Part I. | 23b. Did | obacco use cor | ntribute to the c | ause of death? |
| ۵. | v requiras thet tha de bean signed by the should be datached | | | | | | | | 1 🗆 | Yes 2□ No | 3 Probably | 4 ⊞t/nknown |
| g | requiras thet bean signed b should be data | d by | | | | | | | 24a. Was | an autopsy | 24b. Were au | |
| ខ្ល | v req bear shou | Completed | | | | | | | | rmed? | available completi of death? | on of cause |
| e E | The taw ate has b pege 2 s | | | | | | | | 100 | 198 2ETNO | | 2□ No |
| <u>ra</u> | i clan: The cartificate ractor, peg | | 25. Was case referred to medical | | | | | 26 Place of De | eath (Check only o | | 1 103 | 20140 |
| > | Physician: r this cartific aral diractor, | To Be | examiner? | Hospital: | nt_ 2□ ER/ | Outpatient | 3□ DOA Oth | or. | Home 5□Resid | 100 | er (Specify) | |
| | ding Phy h. After this funeral | | 27. Menner of Deeth 1 ☑ Natural 5 ☐ Pending | 28e. Date of Injury (Month, Day) | v 28b | . Time of Injury | 28c. Injur Worl | | | now injury occurr | | |
| S | Attending ir death. ector: Afte by tha fune | cati | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be | | | | | Yes 2 □ No | 2011 11 1 | | 0.10 | |
| | or At after c Direct I in by | Certification: | 4 Homicide determined | 28e. Place of Inju- building, etc. | | farm, stree | t, factory, office | | City or Tox | Street and Numb m, State) | er or Hurai Hout | e Number, |
| | To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this cartificate he completely filled in by the funeral director, pege | edicai C | 29a. Certifier (Check only 2 Medical Exam) | sician: To the best of ner: On the basis of | my knowled | ge, deeth o | ccurred et the tin | ne, date and place | e, and due to the | cause(s) and ma | nner as stated. | ause(s) |
| | the hin 24 the F nplete | Med | one) | end manner stat | | | | | | | | |
| | Vithing to the transfer of the | | 29b. Signature and title of certifier | 20 | n | ND | 29c. Licens | 4 1 4 | | 29d. Date signed | Montin, Day, Y | ed!) |
| | | | / / / / / / | V | | | | 1 7 9 1 | | - 12 | 0/00 | |
| | 1 | | 30. Name and address of person who co | Blomb S | 35 (1) | V. 8 | Now V | r Fm | €, 30€ | Bell | mry M | 11) 2120 |
| | Sta Registr | te ar | 31. Date filed (Month, Day, Year) FEB 2 1 2 | 008 32. Angistra | 's Signatur | A STATE OF THE PARTY OF THE PAR | 2492 | | | | | |

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0629 M JOSEPH STUMP EBRUARY JOHN 18 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HESTER TOWN 1 Year | If Under 24 Hrs. | 8. Date HOSPITAL CENTER KENI HESTER RIVER 8. Date of Birth (Month, Pay, Year) 3/27/1914 Birthplace (State or Foreign Country) 5. Social Security Number Age (In vrs. last birthday) 1**∑**M 2□F Months Days Hours 212-01-8915 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 X No QUEENS ANNE CHURCH HILL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21623 555 MAIN STREET 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Specify: WHITE 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRINTER PRINTING CO. 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HELEN C. MCKEWEN JOHN J. STUMP, SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1214 SAINT ANDREWS WAR BALTIMORE, MD HELEN R. TRENTLER/NIECE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State NEW CATHEDRAL CEMETERY 2/23/2008 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial Due to (or a a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

attending physician and for use as the burial-tran

signed by the a

certificate has the rector, page 2 s

funeral director.

this

After

Director

within 24 hours

To the Funeral

completely filled

Be

Certification: To

Medical

State

The law requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

To the Hospital or Attending Physician:

death.

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

ms 23a or 2 must be n

? Is marked other than "natural", or items traumatic event, the Medical Examiner mu

al Hygiene.

Is marked of

Department of Health au Important: If item 27 Is any injury or other trau

· death v

filed within 72 hours after

Pages 1 and 2 should be

3altimore, Maryland 21215-0036

Director

Funeral

ģ

Completed

Be

2

Sequentially list conditions, immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner

27. Manner of Death

Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

24a. Was an was ... autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work?

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of erson who completed cause of death (Item 23a) (Type, Print)

Dr. Delboy 6602 Church Hill Road

31. Date filed (Month, Day, Year)

2008 FEB

5 Pending investigation

6 Could not be

determined



MD

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEB Day Year **Physician** 2:08 M SMITH ESSE 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANN E ARUNDEL 2062 ASHLEY DRIVE ANNAPOLIS If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**3** M 2 ☐ F 213-03-43 Director Ug, 31,191 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland I and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No ANNAPOLIS Director ANNE ARUNDEL MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ASHLEY DRIVE 21401 2062 UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: BLACK Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INDUSTRIAL NAINTENANCE UNK 18. Mother's Name (First, Middle, Maiden Surname) UNIC 17. Father's Name (First, Middle, Last) in I Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is π any injury or other traum once. FRIEND J ONES ASHLEY DR. ANNAPOLIS, MD 21401 IHERESA 206Z 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 2/26/08 ANNAPOLIS, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dicens 22. Name and Address of Facility / MILLER'S METROPOLITAN CHAPEL 1639 N. BROADWAY BALTO., Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that prused the death. It is not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause or each line. Immediate Cause (Final disease or condition resulting in death) **Physician** D MU /Medical Due to (or as a consequence of) **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and be detached for use as the burial-transi Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 ZiNatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar 29b. Signature and title of

Date filed (Month, Day, Year)

ype, Print)

of death (Item 23a)

32 Registrer's Signature

License number

29d. Date signed (Month, Day, Year)

| | | | 1 = For State Registrar | State of Maryla | | irtment of | | | iene () () 8 | 05282 |
|--|--|---------------------------|--|---|--------------------------------------|--|---|---|---|--|
| 184 | Physici | | Decedent's Name (First, Middle, Last) | George | _ | eene | | 2. Date of Death Month Februar | h Day Year | 3. Time of Death |
| 1 | /Medic Examir | | 4a. Facility Name (II not institution, give | NWSING | Cente | 4b. City, Town | or Location of Dea | ure | 4c. County of Dea | th |
| 10000000000000000000000000000000000000 | Funeral Director | | 5. Social Security Number 6. Se 212-28-3658 Usual Residence of Decedent | M 2DF | 5. last birthday) 77 Yrs. | Months Days | | | Year) 9. Bir O Man | thplace (State or Foreign ountry) Y Land |
| | aryland show | 25 | 10a. State 10b. County | 10c. C | City, Town or Lo | | | | | 10d. Inside City Limits 1 ☐ Yes 2 ■No |
| | th the M or 28a-f e notifie | Director | MD Howard 10e. Street and Number | | Elk | ridge 101. Zip Code | | 10 | 0g. Citizen of What C | |
| | sath wires | erai C | 6554 Ducketts Lan | e 12. Was Decedent Ever in | 118 113 1 | | .075 | Specific Ves or No. | USA 14. Race - Am | ancan Indian |
| 39 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other then "natural", or items 23s or 28s-f show important: if item 27 is marked other then "natural", or items 23s or 28s-f show all hyllight or other traumatic event, the Medical Exam that must be notified at ance. | by Funerai | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | Armed Forces? 1 2 Yes 2 □ No If Yes, Give Year or Dates: | | Yes, specify Cul | | Specify Yes or No- rto Rican, etc.) | Black, Whi | |
| 21215-0036 | ithin 72 ho ie. ien "natur i Medical I | Completed | 15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) | | (Give | lent's Usual Occu kind of work done DO NOT use retir | e during most of w | orking | 16b. Kind of Business | VIndustry |
| d 21 | Hygier Hygier Ither th | | 17. Father's Name (First, Middle, Last) | | 1 | Welder | 18. Mother's Na | ame (First, Middle, N | General Mo Maiden Sumame) | tors |
| Maryland | uld be Vental orked o | To Be | Howard Sweeney | | | | Leon | a Waldman | | |
| Mary | 12 should h and Men 7 Is marke traumatic | | 19a. Informant's Name/Relationship (T) | | | | | | City or Town, State, | |
| | s 1 and f Health item 27 other tr | | Mrs. Josephine Swe | 20b. | Place of Dispos | Ducketts sition (Name of patory or other pl | | | Maryland 2 20c. Location - City of | |
| Baltimore, | Pages ment of ant: If its ury or o | | 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) | | - | rk Cemet | | /21/08 | Baltimore, | Maryland |
| Bal | Departition Depart | | 21. Signature of Funeral Service Licens | P | 4 | . Name and Addi そ20 なも11 | | | rk Funeral e, Marylar | |
| | Dhysisian | | 23a. Part1. Enter the disease, or composhock, or heart failure. List only o | ications that caused the deane cause on each line. | | er the mode of dy | ing, such as cardi | ac or respiratory arre | | Approximate Interval Between Onset and Death |
| | Physician /Medical Examiner | | disease or condition resulting in death) | Due to (or as a conse | equence of); | neu | Monic | | | 4 days |
| | Examine | er | Sequentially list conditions, if any, leading to immediate | Due to (or as a conse | SONS equence of): | dis- | ease | | | years |
| | ocuted and transit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | | Vears | | | | | |
| 8760, | icate be executed physician and s the burial-transit | dical Ex | resulting in death) Last | | | 1 | | | | |
| 9 | rtificate ng phys as the | Medic | IF FEMALE: | D | | | | | | |
| .O. Box | The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Completed by Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 3c. If yes, outcome of preging 1 ☐ Live birth 2 ☐ Fer 4 ☐ Pregnant at time of 9 ☐ Unknown | tal death 3 🗌 | Ectopic pregnant Other (specify) | су | | 23d. Date of de Month | blivery Day Year |
| rds, P | w requires that been signed b should be deta | ed by PI | Part 1 Other significant conditions conditio | ntributing to death but not re | esulting in the ur | nderlying cause g | pven in Part I. | 23e. Did tob | | to the cause of death? |
| Division of Vital Record | | Complet | Hypertens | m | | | | 24a. Was ar autops perform 1 Yes 2 | y prior to | utopsy findings available completion of cause of s 2 \(\square\) No |
| Vita | Physician: this certificant | o Be | 25. Was case r ferred to medical examiner? 1 □ Yes 2 No | Hospital: 1 ☐ Inpatient 2 (| ☐ ER/Outpatien | t 3 DOA | . 10 | eath (Check only on | ence 6 Other (Spe | no (fu) |
| ion of | Attending Phy ir death. ector: After this by the funeral d | ation: To | 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Inj | | | w injury occurred | ec.iy) |
| Divis | To the Hospital or Attending Ph witnin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injury - At building, etc. (Spec | home, farm, stre cify) | eet, factory, office | 3 | 28f. Location (St. City or Town | reet and Number or F n, State) | Rural Route Number, |
| | To the Hospital or within 24 hours after To the Funeral Director completely filled in I | edicai | 29a. Certifier 1X Certifying Phy (Check only one) 2 Medical Exami | sician: To the best of my kr ner: On the basis of examinand manner stated. | nowledge, death nation and/or inv | occurred at the restigation, in my | time, date and place opinion, death occ | ce, and due to the ca curred at the time, da | ause(s) and manner a ate and place, and du | s stated. e to the cause(s) |
| | To the within 2 To the complet | Me | 29b. Signature and title of certifier | 111- | - 1000 | 29c. Licer | nse number | | 9d. Date signed (Mon | _ |
|) h | 7 | |) | 7 | | | 1553 | 91 1- | ebrucy | 18,2008 |
| 3 | -1] | | 30. Name and address of person who or | empleted cause of leath (Ite | am 23a) (Type, | eneu. | Balti | more 1 | rebrucry Marylan | 18, 2008 d 21227 |
| | Sta Registr | | 31. Date filed (Month, Day, Year) FEB 2 1 2008 | 32. Registrar's Sign | nature | E) | 2.71 | | 1 | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend 19b, per FH g876, 2/21/08 TT Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 10:06 P™ FEBRUARY 18 2008 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL OF BALTIMORE BALTIMORE N/A Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Months Hours 1 □ M 2 👿 08/05/1911 NC 96 219-56-4442 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No MD N/A BALTIMORE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hygiene. 7111 PARK HEIGHTS, #803 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 2 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME Pages 1 and 2 should be filed inent of Health and Mental Hyginnt: If Item 27 Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MAZUR ISAAC COHN SARAH 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7111 PARK HEIGHTS AVE. PAUL SCHENKER / HUSBAND 21215 BALTIMORE, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition ANSHE EMUNAH AITZ CHAIM CONG. Important: If it any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 02/20/2008 BALTIMORE, MD 4 ☐ Donation 5 Other (Specify) SOL LEVINSON & BROS., INC. of Funeral Service on 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or com shock, or heart failure. List only caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ispare Immediate Cause (Final Jundy. **Physician** was disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, but in a large transport cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner A pie attending physician and attending to use as the burial-transit the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the at d be detached for 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 🗌 Yes been si should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? Yes 2 2 No 2 No 1 ☐ Yes 1□ Yes Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 X ER/Outpatient 3□ DOA ၉ this funeral 27. Manner of Dath 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? Certification: After 5 Pending investigation (Month, Day Year) Injury 1 Natural 2 Accident To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide r Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie cath (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

FEB 2

2008

DHMH 17 Rev 1/2001

| | | • | For State Registrar | State of Maryland | _ | artment of He rtificate of E | | | leg. No. | 008 | 05284 | | | | |
|-------------------|---|----------------|---|--|---|---|------------------------------|--|-------------------------|----------------------------------|---|--|--|--|--|
| E | Physicia | n | 1. Decedent's Name (First, Middle, Last) JOSEPH | | STERNI | FELD | | 2. Date of Dea | | 2008 | 3. Time of Death 6:45 PM | | | | |
| | /Medic Examin | Name and | 4a. Facility Name (If not institution, give str | | | 4b. City, Town, or | | | | 4c. County of Death | | | | | |
| | | 43 | LEVINDALE HEBREW H | | 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. | | | | | N/A | loca (Ctata or Foreign | | | | |
| | Funeral Director | | 219-01-0520 | 7. Age (in yrs. ii 88 | Yrs. | Months Days | Hours Min. | 8. Date of Birth (Month, Day 02/07/1 | 920 920 | Coun | lace (State or Foreign try) MD | | | | |
| | land ow | ŀ | Usual Residence of Decedent 10a. State 10b. County | 10c. City | , Town or Lo | ocation | | | | 1 | 0d. Inside City Limits | | | | |
| | a-f sh | ctor | MD N/A | | BA | ALTIMORE | | | | | 1 X Yes 2 □ No | | | | |
| | or 28 | Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citize | en of What Coun | itry? | | | | |
| | s 23a nust | eral | 2434 W. BELVEDERE | . Was Decedent Ever in U.S | 2 10 | 212 | | acifu Vac or No- | 1, | USA 14. Race - American Indian, | | | | | |
| 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Fur | 11. Marital Status 1 □ Never Married 2 □ Married 3 🂢 Widowed 4 □ Divorced | Armed Forces? 1 M Yes 2 □ No WW If Yes, Give Year or Dates: | | Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2🂢 No | Specify: | Rican, etc.) | | etc. | | | | | |
| 5-0 | 72 hc "natur | eted | 15. Decedent's Educa (Specify only highest grade of | tion completed) | 16a. Dece (Give | dent's Usual Occupa kind of work done d DO NOT use retired, | ation Juring most of work | ing | 16b. Kin | d of Business/Inc | dustry | | | | |
| 121 | within ene. than h | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | | DO NOT use retired, EWELER | , | | JI | EWELRY | | | | | |
| | il Hygi other ent, t | Be Co | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Name | | | | | | | | |
| ylar | Menta Menta arked atlc ev | 10 E | OTTO | STERNF | | | RACH | | | OSENTHAL | | | | | |
| Maryland | 12 sho h and 7 is m traum | | 19a. Informant's Name/Relationship (Type PHYLLIS CLYMER / I | | 1 | ng Address <i>(Street a</i> L MAD RIVE | | ral Route Numbe | | | | | | | |
| | Healt tem 2 | | 20a. Method of Disposition | 20b. P | lace of Dispo | osition (Name of | | Date | | ation - City or To | | | | | |
| altimore, | Pages ment of tant; If It | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify) | moval from State ARC AMU | NO COL | | : 02/2 | 0/2008 | | TIMORE, | | | | | |
| Ball | permit Depar Impor any In once, | 2 | 21. Sign to e Funeral/Service Acense | maer | | 2. Name and Addres 3900 REIS | | | | & BROS., SVILLE, | | | | | |
| Г | ÷ | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Approximate Interval Betty Onset and D | | | | | | | | | | | | |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): | | | | | | | | | | | | |
| | Examiner | | | Due to (or as a consequ | ience of): | | | | | | | | | | |
| | Dr. / # | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Dise to (or as a consequ | sence of): | | | | | | | | | | |
| | ficate be executed physician and s the burial-transit | Examiner | that initiated events resulting in death) Last | Due to (or as a consequ | equence of): | | | | | | | | | | |
| 68760, | e be e /sician e buriz | edical E | d. | | | | | | | | | | | | |
| _ | rtificat ng phy as the | /ledi | IF FEMALE. | | | | | | 12 | | | | | | |
| P.O. Box | that the death certificate be executed ed by the attending physician and detached for use as the burial-transit | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown | | | 2 | 23d. Date of delivery Month Day Year | | | | | | | |
| | es ign be | by Pl | Part I. Other significant conditions cont | nibuting to death but not resu | ulting in the u | inderlying cause give | en in Part I. | 23e. Did t | _ \ | 1 | he cause of death? bably 4 ☐ Unknown | | | | |
| ord | v requir been si should b | eted | Sevienta, in | g perte now |) | /11/00/ | | | 7 | | | | | | |
| or Vital Records, | The lay ate has page 2 | Completed | - Novillann | | | | | 1□ Yes | psy prmed2 2 X No | prior to co death? | opsy findings available ompletion of cause of | | | | |
| Z; | Physiclan: this certific | o Be | 25. Was case referred to medical examiner? | ospital: 1 Inpatient 2 | ER/Outpatie | nt 3 DOA Othe | er: 4 Jursing H | | | □Other (Speci | (fy) | | | | |
| n or | | n: To | 27. Manner of Death 1 → Natural 5 → Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time o | | | 28d. Describe | | | | | | | |
| Sion | Attending r death. ector: After y the fune | catio | 2 Accident investigation 3 Suicide 6 Could not be | | | M 1 | Yes 2 □ No | 001 1 11 1 | | I.M. at an Daniel | 10 | | | | |
| Division | al or At s after d al Direc | Certification: | 4 Homicide determined | 28e. Place of injury - At ho building, etc. (Specif | | reet, factory, office | | City or To | | | al Route Number, | | | | |
| | To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the | edical (| | cian: To the best of my kno er: On the basis of examina and manner stated. | | | | | | | | | | | |
| | To the within 2 To the сотрые | Me | 29b. Signature and title of certifier | 1 | | 29c. Licens | e number | | 29d. Date | e signed (Month | , Day, Year) | | | | |
| | 1 | | my m | Jus J | | 03 | 3943 | | 02/ | 19/20 | 800 | | | | |
| | b | | . //. / . / | npleted cause of death (Iten | 1 23a) (Type | Print) 24 | 3411 | Belis | را | 212 | 15 | | | | |
| | Sta | ite | 31. Date filed (Month, Day, Year) | 32. Registrar's Signa | ture | | | ,0000 | | | | | | | |
| | Regist | rar | FEB 2 1 ZUU8 | | 1 | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Barry James Taylor February 20, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6 Cider Court Baltimore Middle River If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**XX**MM 2 □ F 09/10/1955 200-46-5867 52 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at Maryland Baltimore 1 ☐ Yes 2XXIo Middle River Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 Cider Court 21220 U.S.A. 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2XX\o If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: þ Yes, Give Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Stationary Engineer Waste Management 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be i is marked James Robert Taylor Lois Marie Ford 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health a Tia Abell (Daughter) 9834 Matzon Road, Baltimore, Maryland 21220 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 permit. Pages
Department of
Important: if it
any injury or o ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb. 21, 2008Baltimore, Maryland Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
1407 old Eastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Licenses 23a. Part . Entire the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi L Cause (Final diseas) or condition resulting in death) Physician /Medical Due to (or a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed burial-transit Due to (or as a consequence of) Box 68760 nding physician Physician/Medical the ass 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 Unknown 9∏Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Ś 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? res 2 No certificate Hyperins 1☐ Yes Division or Vital 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 🔲 Inpatient c 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. after death 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

loused attarasio

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0-28097

use or death (nem 23a) (Type, Print)

9144 Philadelphialld - Swite 108; Bolt., Nd. 21237

| | | | | Please | Type or Prin | | | | | | | | - | | |
|--------------------------------|--|-------------------|--|---|---|--------------------|-------------------------------|-------------|--------------------------|--|------------------------------------|-------------------------|------------------------------------|-----------------------------|-----------------------------|
| | | | For State Registrar | | State of Ma | aryıan | - | ertifica | | | wental H | ygien Reg. N | Z U U D | 0.5 | 286 |
| | Dhuaisi | 朱 | | ne (First, Middle, Las | st) | | | | | | 2. Date of D | eath | ay Year | 3. Time | e of Death |
| 8 | Physici /Medic | | | ENE THOMP | | | | | | | FEBRUA | RY | 16, 2008 | 8:4 | +5P ^M |
| | Examin | er | | | e street and number) | | | | | r Location of Deat | | 4 | c. County of Deat | | |
| · or | Funeral | | 5. Social Security N | OSS HOSPI'S | | e (In yrs. | last birthday | /) If Unde | er 1 Year | | 8. Date of B | irth | MONTGO 9. Birt | hplace (Sta | te or Foreign |
| | Director | | 244 80 9 | 9072 | □ M XX) F | 5 | 8 Yrs. | Months | Days | Hours Min. | OCT. 2 | | | untry) TH CAI | ROLINA |
| | w w | | Usual Residence of 10a, State | f Decedent 10b. County | | 10c. Cit | y, Town or l | ocation | | | | | | 10d. Inside | City Limits |
| | Maryli f sho | tor | MD | PRINCE G | FORCES | | RESTV | | | | | | | | es 2□No |
| | n the | Director | 10e. Street and Nu | | до кодр | 10. | KIDI V. | | ip Code | | | 10g. C | Citizen of What Co | untry? | |
| | ath wil | ral | 6527 HII | MAR DRI | | | | | 2074 | - | | | UNITED | | |
| | items | Funeral | 11. Marital Status | ried 2 Married | 12. Was Decedent I Armed Forces? | | .S. 13 | If Yes, sp | edent of H ecify Cuba | lispanic Origin? (S an, Mexican, Puer | pecify Yes or N to Rican, etc.) | lo- | 14. Race - Ame Black, White | | , |
| 336 | be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | b | 3 ☐ Widowed | | 1 ☐ Yes XXX 1 If Yes, Give Year or Dates: | 10 | | 1 ☐ Yes | 3€XNo | Specify: | | | Specify: BL | ACK | |
| 2-0 | 72 hou natura ilcal E | Completed | /Spe | 15. Decedent's Ec | | | 16a. Dec | edent's Usi | ual Occup | ation | rkina | 16b. | Kind of Business/ | | |
| 2 | within iene. | mple | Elementary/Seco | | College (1-4or 5 | 5+) | | | | during most of wo | | 7777 | 17 mm 0 1 mm | - / O.T.D.T | |
| d 2 | be filed within 72 hortal Hygiene. d other than "natuevent, the Medical. | | 17. Father's Name | (First, Middle, Last) | 1+ | | ADI | MINIS | TKATI | VE ASSIS | | | ALTH CAR | E(SIRI | LEY) |
| <u>a</u> | should be filed vand Mental Hygies s marked other t | To Be | | THOMPSON | | | | | | MILLIE | | | , | | |
| ary | 2 shou and M Is mar aumat | ۲ | | lame/Relationship (| Type. Print) | | 19b. Mai | ling Addres | ss (Street | | | | or Town, State, 2 | Zip Code) | |
| Σ | = - | | | POSTELL / | SISTER | | | | | RIVE #30 | | | TVILLE, I | | |
| Baltimore, Maryland 21215-0036 | ages 1 nt of H if ite or ot | | 20a. Method of Dis | ☐Cremation 3 ☐ | Removal from State | 0 | Place of Disp cemetery, cr | ematorý or | other plac | i i | Date | | Location - City or | Town, State | • |
| <u>t</u> i | nit. Pa artmer ortant: injury | | | 5 Other (Specify uneral Service Licer | | RES | | | | TERY 02/ | | | INTON, M | | |
| Ba | permit. Pages 1 and Department of Healt Important; if item 2' any Injury or other I | | DIR | | CRAY | | l l | ARSHA | ALL'S | FUNERAL AND ROAD | HOME C | F MAND | ARYLAND, , MD 2074 | INC. | |
| | | | 23a. Part1. Enter shock, or hea | the disease, or com art failure. List only | plications that caused one cause on each lir | the deatl | | | | | | | , 110 207 | Approxii Interval | nate Between |
| | Physician | | Immediate Cause disease or condition | on | a CARDIOP | ULMOI | NARY A | ARREST | Γ | | | | | Onset a | nd Death |
| | /Medical Examiner | | resulting in death) | | Due to (or as | | | | | | | | | | |
| | | ē | Sequentially list co | onditions, | b. END STA | | | LE SCI | LEROS | SIS | | | | | |
| | be executed sician and burial-transit | Examine | if any, leading to it cause. Enter Undo Cause (Disease or that initiated event | erlying r injury s | C. | | | | | | | | | | |
| 60, | be executed cian and burial-transit | | resulting in death) | Last | Due to (or as | a conseq | uence of): | | | | | | | | |
| | cate by | Physician/Medical | | | d | | | | <u> </u> | | | | | | |
| Box 687 | death certificate b attending physic I for use as the bi | /Me | IF FEMALE: | | 23c. If yes, outcome | pf pregna | апсу | | | | | | 23d. Date of del | iven/ | |
| | death e atter d for u | iciar | 23b. Was deceder in the past 12 1 ☐ Yes 2 | 2 months? | 1 ☐Live birth 4 ☐ Pregnant at | | | □Ectopic p | | / | | | Month | Day | Year |
| 0. | that the de ned by the a | hys | 9 🗆 Unknowr | 1 | 9□ Unknown | | | | | | | | | | |
| <u>'S</u> | The law requires that the death certificate ate has been signed by the attending physbage 2 should be detached for use as the | by F | Part II. Other signi | ificant conditions o | ontributing to death be | ut not resi | ulting in the | underlying | cause give | en in Part I. | | | o use contribute to | | |
| oro | w requires been signe should be | Completed | - | | · · · · · · · · · · · · · · · · · · · | | | | | | | | 2 No 3 Pr | | |
| Rec | ne faw has t ge 2 s | mple | | | | | | | | | 24a. Wa aut per | s an opsy formed? | 24b. Were au prior to death? | itopsy findir completion | gs available of cause of |
| ta | 10 == | | 25. Was case refe | rred to medical | | | | | | 26. Place of Dea | 1□ Yes | XX | No 1 ☐ Yes | 2 □ No | |
| Z. | Physician; rthis certifica ral director, p | To Be | examiner? 1 ☐ Yes | | Hospital: XX Inpatie | ent 2 🗆 | ER/Outpation | ent 3 D | Oth | | | | 6 ☐Other (Spe | cify) | |
| n o | ng Ph fter th ineral | | 27. Manner of Dea | th 5 ☐ Pending | 28a. Date of Inju (Month, Day | ry y Year) | 28b. Time Injury | of | 28c. Injur Wor | | 28d. Describe | | | | |
| Sio | Attending r death. ector: After by the funer | catio | 2 ☐ Accident 3 ☐ Suicide | investigation | | un. At he | | M (sets | | Yes 2 □ No | 000 1 1 | , C | | 100 | |
| Division or Vital Records, P.O | l or Ai after o Direc | Certification: | 4 ☐ Homicide | determined | 28e. Place of inju building, etc | c. (Specif | y) | теет, тасто | iry, onice | | City or T | (Street a | and Number or Ru ate) | ırai Houte I | lumber, |
| _ | To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | | 29a. Certifier | XX Certifying Ph | ysician: To the best | of my kno | wledge, dea | ath occurre | d at the tir | me, date and place | e, and due to th | e cause | (s) and manner as | stated. | |
| 1 | To the Ho within 24 To the Fi | Medical | (Check only one) | | niner: On the basis of and manner sta | t examina ated. | ition and/or | | | | urred at the time | | | | |
| | Vitt Cor | 2 | 29b. Signature and | title of certifier | ta | | | 29 | 9c. Licens D64 | | | | Date signed (Mont BRUARY 1 | | |
| | | | 30 Name and add | ress of nomen wh | completed cause of de | oath (lea- | 23a\ /T | Drint) | D04 | | | 1 151 | JACARI I | | |
| | | | S. BHIKE | | | • | , , , , , | | EN RD | . SILVER | SPRING | , MI | D 20910 | | |
| | Sta | | 31. Date filed (Mor | nth, Day, Year) | 32 Registra | ar's Signa | | andi | | | | | | - | |
| | Registr | ar | | EB 2 1 20 | OU SEE SEE | | 100 | -6-6- | | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8 0 8ª 9:15 PM BOBBY FOSTER VELLINES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hyattsville St. Thomas More Nsg. & Rehab. P. G. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 8/25/46 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 M 2 □ F 237-74-0046 61 Director Person County Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 28a-f show ral", or Items 23a or 28a-f shore Examiner must be notified at Director 1 Y Yes 2 □ No D. C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 2 am injury or other traumatic event, the Medical Examiner must be n once. 20011 USA 310 Sherman Avenue, N. W. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 X Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 1□Yes ŽiNo 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Waiter 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lunette Terrell Ernest Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 4609~U.S.~70~- Mebane, N. C. 27302 Yvonne Vellines/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Quality Cremations 2/11/08 Durham, N.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Liegnse 22. Name and Address of Facility Austin Royster Funeral Home - 14th Street, N.W., Wash., DC 20011 3821 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or the relative. List only one cause on each line.

Immediate the (Final disease of condition resulting in death)

a. (Line of the condition resulting in death) Approximate Interval Between Onset and Death Acquired immunedaticisary Disease (AIDS, **Physician** coirs /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown ed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autop. performea : ''as 2 □ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation illed in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day, FEB 2 1

A. DE VORE, MO 4 203 QUEENS SULY Rd Hyaltsville Md 2018/

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

| | | | 1 - State Amend Item Registrar | State of 30 | of Marylan per dr. | d / Depa , g876 | rtment of | Health an dhb <i>Death</i> | d Mental Hy | giene Reg. No. 2 | 008 | 05288 | | | |
|---|---|--------------------|--|-----------------------------------|--|------------------------|--|---|--|-----------------------------|-----------------------------------|--|--|--|--|
| 4. | Physici /Medic | | 1. Decedent's Name (First, Middle, Esther V | | | | 2. Date of De Month | Death Day Year 2008 / 03 75 M | | | | | | | |
| | Examir | | 4a. Facility Name (If not institution, Howard County (| give street and nu | umber) | | 4b. City, Town, | or Location of D | eath | 4c. County of Death Howard | | | | | |
| | Funeral Director | | | 3. Sex 1 ☐ M 2 ☐ F | 7. Age (In yrs. | | If Under 1 Yea Months Days | r If Under 24 | Hrs. 8. Date of Bir Win. (Month, Da Sept 1 | rth ay, Year) | 9. Birthpl Count | ace (State or Foreign ry) MD | | | |
| 17215-0036 within 72 hours after death with the Maryland | Maryland f show led at | or | Usual Residence of Decedent 10a. State 10b. County MD Howard | i | 1 | y, Town or Lo | | | | | | 0d. inside City Limits 1 ☐ Yes 2 ☑ No | | | |
| | with the I 3a or 28a- t be notif | I Direct | 10e. Street and Number 1975 Mt. View Ro | oad | | | 10f. Zip Code | 104 | | 10g. Citizen | of What Count | ry? | | | |
| 9 | after death or Items 23 | y Funeral Director | 11. Marital Status 1 ☐ Never Married 2 ☐ Marrie | Armed F d 1 ☐ Yes If Yes, G | 2 X No | ļ | | Hispanic Origin Iban, Mexican, P | ? (Specify Yes or No Juerto Rican, etc.) | D- 14. F | Race - America Black, White, e | etc. | | | |
| 15-0036 | be filed within 72 hours after death with the Marylar ital Hygiene. cd other than "natural", or ftems 23a or 28a-f show event, the Medical Examiner must be notified at | Completed by | 3 Widowed 4 Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12) | grade completed, | | 16a. Deced | lent's Usual Occ kind of work don OO NOT use retii | upation e during most of | working | 16b. Kind o | f Business/Ind | ustry | | | |
| ZLZ DUI | be filed tal Hygi d other event, t | Be | 17. Father's Name (First, Middle, L. Charles Thompso | +4 _{ast)} | (1-401 5+) | schoo | 1 teache | 18. Mother's | Name (First, Middle | | | education | | | |
| Maryland | 2 should and Mer Is marke aumatic | To | 19a. Informant's Name/Relationshi Mr. Robert E. Wh | p (Type. Print) | enougo) | 1 | • | et and Number o | or Rural Route Numb | | | , | | | |
| aitimore, N | 90 = 6 | | 20a. Method of Disposition | 3 □Removal from | 20b. P | Place of Dispo | sition (Name of natory or other p | lace) | Date 16-08 | 20c. Location | on - City or To | wn, State | | | |
| Balt | permit. Pag Department Important: I any injury c | | 21. Signature of Funeral Service Li | censee , | | 22 | . Name and Add | ress of FacilityH | aight Fun esville, | eral H | ome & C | • | | | |
| ų. | Physician | 6 5 | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death disease or condition resulting in death) a. Due to (or as a consequent of the consequent | | | | | | | | | | | | |
| | /Medical Examiner | L. | Due to (or as a consequentially list conditions | | | | | | | | | | | | |
| 8/60, | cate be executed physician and the burial-transit | al Examiner | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | (or as a consequence | | | | | | | | | | |
| Rox P8/ | the death certificate y the attending phys iched for use as the | an/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 1 ☐Live | utcome pf pregna | Ideath 3□ | Ectopic pregnar | | | 23d. | Date of delive Month | ry Day Year | | | |
| 0.0 | at the dead by the a | Physician/M | 1 Tes 2 No 9 Unknown 9 Unknown | | | | | | | | | | | | |
| Records, | w requires that the d been signed by the should be detached | þ | Part II. Other significant condition | is contributing to o | Death but not rest | uiting in the ur | nderlying cause g | jiven in Part i. | 1 | | | e cause of death? ably 4 □Unknown | | | |
| | The larate has | Completed | | | | | | | — 24a. Was auto perfi 1∐ Yes | | prior to con death? | osy findings available npletion of cause of 2 ☐ No | | | |
| r vital | <u>> .≅</u> ₽ | o Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No | Hospital: | Inpatient 2X | ER/Outpatien | t 3 DOA | thor | Death (Check only only only only only only only only | | Other (Specify | ·) | | | |
| ion or | Attending Physr death. ector: After this by the funeral di | ation: T | 27. Manner of Death 17 Natural 5 Pending Accident investiga | tion | of Injury nth, Day Year) | 28b. Time of Injury | W | | 28d. Describe | | | | | | |
| DIVISION | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Certification: | 3 ☐ Suicide 6 ☐ Could no determin | ed 28e. Plac build | e of injury - At ho ding, etc. <i>(Specif</i> | y) | | | City or To | wn, State) | | Route Number, | | | |
| \ | e Hosp 124 hou ie Fune detely fi | Medical | | xaminer: On the | | | | | place, and due to the occurred at the time | | | | | | |
| | To the He within 24 To the Fi complete | Me | 29b. Signature and title of certifier | 71. | 00 00 | | 1 | 2078 | g . | 29d. Date sig | gned (Month, | Day, Year) | | | |
| , | 7 | | 30. Name and address of person w | | se of death (It m | | Print) Will | iam Flov | vers,M.D. | 219 | VHIG I | 7 200 | | | |
| 0 | Sta | | 31. Date filed (Month, Day, Year) | le VA | Registrar's Signa | ture | -Olun | nba, | MID | 210 | | | | | |
| ¥ | Registr | ar | FEB 2 1 2 | UUO DUU | 1000 100 | 1500 | | | | | | | | | |

DHMH 17 Rev 1/2001

| | | | | For State Registrar | State of Ma | ıryland / [| | rtment of H | | d Mental Hy | /giene Reg. No | 2000 | 05289 | |
|---------|--------------------------------|--|------------------|--|---|---|-------------------|--|----------------|----------------------------------|---|----------------------------|--|--|
| | | Physicia /Medic | | 1. Decedent's Name (First, Middle, Last) Sophie Harobin Wa | gner | | | | | 2. Date of D Month Februar | eath y 18, | ^y 2008 Year | 3. Time of Death 8:20 P M | |
| | | Examin | | 4a. Facility Name (If not institution, give s Harford Memorial | | | | 4b. City, Town, or Havre d | | | 40 | County of Deat Hari | | |
| | | Funeral Director | | 5. Social Security Number 6. Sex 163-24-3494 | | (In yrs. last bii 79 | rthday) Yrs. | If Under 1 Year Months Days | If Under 24 I | 8. Date of B (Month, D | inth Pay, Year, 7,192 | 9. Birth Co 29 Penn | hplace (State or Foreign suntry) sylvania | |
| | | yland now | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Tow | vn or Loc | | | | | | 10d. Inside City Limits | |
| | | death with the Maryland me 23a or 28a-f ehow rnust be nulffied at | rector | MD Harfo | rd Havre de Grace | | | | | · | 1 ☐ Yes 2 | | | |
| | | 23a or | Funeral Director | 1327 Superior Str | eet 2. Was Decedent B | | 1.0.11 | 21078 | | | | | | |
| | | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Item 27 Ie marked other then "naturel", or Iteme 23a or 28a-1 ehow any Injury or other traumatic event, the Mudical Examiner must be multiled at once. | þ | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ ※ Midowed 4 □ Divorced | lo | 13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes 2XXIIo Specify: | | | | 0- | 14. Race - Ame Black, Whit Specify: | | | |
| | Baltimore, Maryland 21215-0036 | ithin 72 h ie. ien "natu i Madical | Completed | 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) | (Give Iife. L | | | ent's Usual Occupation of work done of NOT use retired | turina most of | working | | Gind of Business M Rest | · · | |
| | nd 21 | at Hygier I other th | Be Cor | 12 17. Father's Name (First, Middle, Last) | | | Owne | 3L | | Name (First, Middl | | Sumame) | | |
| 0 | aryla | should bund Ment | 10 | Vasil Harobin 19a. Informant's Name/Relationship (Type | oe, Print) | | | | and Number o | a Pokojn: | ber, City | | | |
| 0 | e, M | 1 and 2 Health a tem 27 le | | Karen Zelman -frie 20a. Method of Disposition | nd | 20b. Place o | of Dispos | ition (Name of | 1 | t-Havre o | | cace, Mar | yland 21078 Town, State | |
| N | timo | t. Pages tment of tant: If I | | 17∰Burial 2 □ Cremation 3 □ Ri- 4 □ Donation 5 □ Other (Specify) | | | ir Me Gard | atory or other place emorial dens | Fe | b.21,2008 | | Air, Ma | | |
| | Bai | Depar Impo any Ir | | 21. Signature of Funeral Service Conse | wholky | 1 | Eva And | Name and Address ns Funer Cremati | al Cha | Vices | | t Drive Hill,M | | |
| | | Physician | | 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only on Immediate Cause (Final disease or conditions) | cations that caused e cause of each lin | the death. Do | not ente | r the mode of dyin | g, such as car | diac or respiratory | arrest, | | Approximate Interval Between Onset and Death | |
| 108 | | /Medical Examiner | | disease or condition resulting in death) a. | | | | | | | | | Tang | |
| 2/18/08 | λχ | ned insit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury | Due to (or as | consequence | of): | · i ga | | | | | | |
| | 760, | ate be executed hysicien and the burial-transit | icai Exa | that initiated events resulting in death) Last | Due to (or as a | a consequence | ence of): | | | | | | | |
| | 68 | certificate nding phys use as the | | IF FEMALE: | 2-14 | | | | | | | | | |
| hie | .O. Box | death e etter d for u | Physician/Med | 23b. Was decedent pregnant in the past 12 menths? 1 Yes 2 No 9 Unknown | 3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown | 2 Fetal death | | Ectopic pregnancy Other (specify) | | | | 23d. Date of de Month | livery Day Year | |
| do | ds, P | uires that signed b | þ | Part II. Other significant conditions con | tributing to death bu | ut not resulting | in the un | derlying cause give | en in Part I. | | | | o the cause of death? | |
| 5 | of Vital Records, | The law requires that the site by the bas been signed by the page 2 should be detached. | Completed | Shalie (), Dla | beles | | | | | 24a. Wa aut | s an opsy formed? | prior to death? | utopsy findings available completion of cause of | |
| 73 | /ital | Physicien: Tr this certificete ral director, pa | Be | 25. Was case referred to medical examiner? | | / | | 1 ou | | 1 ☐ Yes Death Check only | 2 /2 /N | o 1 Yes | ; 2□ No | |
| aub | | ng Physi fter this c | on: To | 1 Yes 2 No | ospital: 1 Inpatie 28a. Date of Injur (Month, Day | nt 2 ER/O y Year) 28b. | Time of Injury | 3□ DOA Oth | 4 LI Nursir | 28d. Describe | | | ocify) | |
| Jac | Division | To the Hospital or Attending within 24 hours effer death. To the Funeral Director: After completely filled in by the funer | Certification: | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. Place of Injubuilding, etc. | ury - At home, fi | arm, stre | | Yes 2 □ No | | (Street a | | ural Route Number, | |
| | | Hospital | edical Ce | 29a. Certifier (Check ority one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check ority one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | s stated. e to the cause(s) | |
| | | To the within To the comple | Med | 29b. Signature and title of certifier | and manner sta | | | 29c. Licens | 79 | 5 | 29d, D | ate signed (Mon. | th, Day, Year) | |
| | | 15 | | 30. Name and address of person who co | 1 . | eath (Item 23a) |) (Type, F | HOO (| | | X P | of 02 | 70 | |
| | | Sta | te | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROSE KURTOM, MD 5015. UNION AVE HAVE de GRACE, MO. 21078 31. Date filed (Month, Day, Year) 1 2008 32. Registrar's Signature TER 2011 2008 32. Registrar's Signature | | | | | | | | | | |
| | | Registr | | FERGIS | 100 | Tool July | | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene

| Physician | |
|-----------|--|
| /Medical | |
| Examiner | |

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760,

Sta Regist

| • | 1- State Registrar Certificate of Death Reg. No. 2008 0529 | | | | | | | | | | | |
|--|--|--|---|--|--|--|--|--|--|--|--|--|
| | 1. Decedent's Name (First, Middle, Last) | | Date of Death Month Day Year | 3. Time of Death | | | | | | | | |
| an al | Richard Lyman Wershiner | | February 18, 2008 | 7:24p M | | | | | | | | |
| er | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Deat | | | | | | | | | |
| | Frederick Memorial Hospital | Frederick | Frederic | k | | | | | | | | |
| | 5. Social Security Number $213-66-0266$ 6. Sex 1% M $2\Box$ F 7. Age (In yrs. I | ast birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth 9. Birth (Month Day, Year) Peb 5, 1954 New | thplace (State or Foreign ountry) York | | | | | | | | |
| | Usual Residence of Decedent | | | | | | | | | | | |
| _ | | | | | | | | | | | | |
| cc | Maryland Frederick | 1 □ Yes 2 No | | | | | | | | | | |
| I Dire | 10e. Street and Number 5640 Wade Court | 10f. Zip Code 21701 | 10g. Citizen of What Co USA | ountry? | | | | | | | | |
| ner | 11 Marital Status 12. Was Decedent Ever in U. | S. 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto | ecify Yes or No- 14. Race - Ame | | | | | | | | | |
| Completed by Funeral Director | Armed Forces? 1 | 1 ☐ Yes 🌠 No Specify: | Rican, etc.) Black, Whit | | | | | | | | | |
| eted | 15. Decedent's Education (Specify only highest grade completed) | 16a. Decedent's Usual Occupation (Give kind of work done during most of work) | 16b. Kind of Business/ | /Industry | | | | | | | | |
| omple | Elementary/Secondary (0-12) College (1-4or 5+) | (Give kind of work done during most of worki life. DO NOT use retired) Engineer | Federal Go | wernment | | | | | | | | |
| ပ္ | 17. Father's Name (First, Middle, Last) | | e (First, Middle, Maiden Surname) | VCLIMICITO | | | | | | | | |
| To Be | Harry Wershiner | Doroth | ny G. Doubleday | | | | | | | | | |
| | 19a. Informant's Name/Relationship (Type. Print) | 19b. Mailing Address (Street and Number or Run | al Route Number, City or Town, State, 2 | Zip Code) | | | | | | | | |
| | Carrie Wershiner, Daughter | 5640 Wade Court Frederi | | | | | | | | | | |
| | Carrie Wershiner, Daughter 5640 Wade Court Frederick, Maryland 21701 20a. Method of Disposition 2 Date 20c. Location - City or Town, State 2 Community or other place) 2 Community or other place 2 Communit | | | | | | | | | | | |
| | 21. Signature of Funeral Service Leensee Thomas Gregor 22. Name and Address of Facility Of Maryland, Inc. 23. Name and Address of Facility Of Maryland, Inc. 29. Frederick Road Baltimore, Maryland 21228 | | | | | | | | | | | |
| | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate | | | | | | | | | | | |
| | shock, or heart failure. List only one cause on each line. | | | Interval Between Onset and Death | | | | | | | | |
| | disease or condition resulting in death) a. Due to (or as a consequence of): | | | | | | | | | | | |
| | Sequentially list conditions, b. Pneumonia | | | | | | | | | | | |
| ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Multiple Capacit Cap | | | | | | | | | | | |
| ami | that initiated events c. | ple Sclerosis | | years | | | | | | | | |
| Medical Examiner | Due to (or as a consequ | dence of): | | 0 | | | | | | | | |
| dic | d | | | | | | | | | | | |
| Completed by Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of do 9 □ Unknown | I death 3 ☐ Ectopic pregnancy | 23d. Date of de Month | 23d. Date of delivery Month Day Year | | | | | | | | |
| Ph | Part II. Other significant conditions contributing to death but not resu | ulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to | o the cause of death? | | | | | | | | |
| ed by | | white ylars, | | robably 4 Unknown | | | | | | | | |
| mplet | | | autopsy prior to performed? prior to death? | utopsy findings available completion of cause of | | | | | | | | |
| ပို | 25. Was case referred to predical | 26 Place of Deet | 1 Yes 2 No 1 No 1 No 1 No 1 No 1 No 1 No 1 No | 2 □ No | | | | | | | | |
| o Be | examiner? | Other: | ome 5 Residence 6 Other (Spe | noifu) | | | | | | | | |
| on: T | 27. Manner Death 1 ☑ Natural 5 ☐ Pending (Month, Day Year) | 28b. Time of lnjury at Work? | 28d. Describe how injury occurred | эсну) | | | | | | | | |
| icati | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of injury - At be | M 1 Yes 2 No | 195 Lanation (Street and Number of F | um I Davita Mumbar | | | | | | | | |
| Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | |
| Medical Certification: To | | l wledge, death occurred at the time, date and place, tion and/or investigation, in my opinion, death occur | | | | | | | | | | |
| Me | 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Mon | th, Day, Year) | | | | | | | | |
| | M. Raza MD | MDD - 66166 | 2/18 | 2/18/06 | | | | | | | | |
| | 30. Name and address of person who completed cause of death (Item | 123a) (Type, Print) 4, Fredendi Menil U | No. to Falik | MA 21201 | | | | | | | | |
| ite | 31. Date filed (Month, Day, Year) 32. Registrar's Signa | ere fresh ! | opplier, leave, | 7/01 | | | | | | | | |
| ar | 31. Date filed (Month, Day, Year) FEB 2 1 2008 39. Registrar's Signa | The state of the s | | | | | | | | | | |

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Feb. Day 2008 ear **Physician** 14, 4:21 A William Guy Wren, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince Georges 7403 Newburg Drive Lanham if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 25, 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Country) Colorado Months Days Hours 1**X** M 2□ F 524-28-9771 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 1 X Yes 2 No Prince Georges Lanham Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20706 USA 7403 Newburg Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XIYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 X☐ No þ 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Researcher U.S. Govt. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Strong William Guy Wren, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7403 Newburg Drive, Lanham, MD 20706 Rita JoAnne Wren 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Laurel, MD MD National Cemtery Feb.22, 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 学1世版 中人名世中39 of 中名州世, INC. Menh 7601 Sandy Spring Rd., Laurel, MD 20707 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, and a ling L immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner use as the burial-transi and Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 4□Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) been signed by the a 2 🗆 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 | Onknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy has 1□ Yes 2 1 LM 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

filled in by the

within 24 hours after death.

To the Funeral Director: After To the Hospital

10

State Registrar

1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28a. Date of Injury

(Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wash & 20010 Deborah Niv

31. Date filed (Month, Day, Year)

FEB21 2008

5 ☐ Pending investigation

6 Could not be determined

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

DHMH 17 Rev 1/2001

ORIGINAL

Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? amend 1,24-27 per Dr. g876 Cartille 408 of 18 De ath 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year AM 0850 Watkins, BB (A) 2008 Januar \mathbf{B} Watkins BALTIMORE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

The Days | Hours | Min. | Dec 31, 2(4a. Facility Name (If not institution, give street and number) 4c. County of Death JOHNS HOPKINS BAYVIEW 6. Sex MEDICAL CENTER Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months 1⊠M 2□F 2007 Maryland none Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County MD Baltimore 1√ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4773 Chetford Avenue 21206 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) none none none none 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) Lystra Watkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4940 Eastern Avenue Baltimore, MD Hopkins Bayview Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) in state 21. Signatule of Funeral Service Licensee Ronald 5. Wade State Anatomy Board 655 W. Baltimore Street lana Baltimore, MD 21201 3a. Part1. shock, Enter the disease, or corp. lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Insufficiency disease or condition resulting in death) Due to (or as a consequence of): Sepsis Due to (or as a consequence of) Prematurity Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

attending physicien and for use as the burial-transit

signed t

peen

this After thi

Director: /

page 2 certificate

The law requires that the death certificate be executed

Attanding Physician:

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medical

ρ

Completed

Be

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Certification:

Medicai

Important: If it any injury or o once.

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f ahow adical Examiner must be rediffed at

other than

Pages 1 and 2 should be fill iment of Health and Mental H tent: If item 27 is marked of

permit. Page Department

Director

Funera

ģ

Completed

Be

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

| not | resulting in the | underlying cause | given in Part I. |
|-----|------------------|------------------|------------------|

| _ |
|---|
| |

24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 【☐ No

1 Yes 2 No 3 Probably 4 Unknown

| | auto perfe | psy ormed? |
|-----------------------|---------------|---------------|
| 26. Place of Death (0 | Check only | one) |

| 1 Tyes | 2 X N | 0 |
|---------------|--------------|---|
| 27. Manner of | | 5 |

2 Accident 3 Suicide

4 - Homicide

25. Was case referred to medical

5 Pending investigation 6 ☐ Could not be

determined

1 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

29a. Certifier

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number RES -600 29d. Date signed (Month, Day, Year) January, 01, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Janine E. Bullard, MD

4940 Eastern Avegue; Registrar's Signature

28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)

Baltimore, MD 21224

State Registrar

DHMH 17 Rev 1/2001

354

within 24 hours of To the Funeral L

31. Date filed (Month, Day, Year) FEB 2 1 B

2008

ORIGINIAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes

| | | | 1 - For amend #26 Per Registrar | r Phy G876 | 2721/08 p | anment of F IH rtificate of I | ieaith and iv Death | rental Hyg | leg. No. | 05295 |
|----------------------------|---|----------------|---|---|--------------------------------------|---|--|-----------------------------------|---|---|
| | Dhyoisi | | 1. Decedent's Name (First, Middle, La | st) | | | | Date of Deat Month | | 3. Time of Death |
| - 3 } | Physici /Medic | | | | ae Witmy | | | | ry 18,2008 | |
| | Examin | er | 4a. Facility Name (If not institution, given 9017 Chesapeake | , | | 4b. City, Town, or | r Location of Death | | 4c. County of Dea | |
| | | | | | In yrs. last birthday) | Edo If Under 1 Year | emere If Under 24 Hrs. | 8. Date of Birth | Balti | |
| | Funeral Director | | | 1□M 2 X F 82 | Yrs. | Months Days | Hours Min. | (Month, Day, Sept. 2 | , Year) | thplace (State or Foreign ountry) ennsylvania |
| | yland now at | | 10a. State 10b. County | 1 | 0c. City, Town or Lo | ocation | | | | 10d. Inside City Limits |
| | e Mar la-f st tiffed | ctor | Maryland Balt | imore | | | Edgemere | | | 1 □Yes 2ሺ‰o |
| | or 28 | Director | 10e. Street and Number | | | 10f. Zip Code | | 1 | 0g. Citizen of What C | |
| | s 23a | ral | 9017 Chesapeak | | . 110 | 2121 | | | United St | |
| 36 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3₺ Widowed 4 ☐ Divorced | 12. Was Decedent Ev Armed Forces? 1 Tes 25 No If Yes, Give Year or Dates: | | Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No | ispanic Origin? (Span, Mexican, Puerto Specify: | ecity Yes of No- Rican, etc.) | Specify: | |
| Maryland 21215-0036 | 72 hou 'natura dical E | ted | 15. Decedent's E | ducation | 16a. Dece | dent's Usual Occup | ation | | 16b. Kind of Business | |
| 215 | within 7; iene. than "n be Medi | Completed | (Specify only highest grant Elementary/Secondary (0-12) | ade completed) College (1-4or 5+) | (Give | kind of work done DO NOT use retired | during most of work d) | ing | | |
| 21 | e filed wi al Hygien other th vent, the | Con | 10 Years | | H | Iomemaker | | | Own Hom | ne |
| and | be fil ntal H ed oth even | Be | 17. Father's Name (First, Middle, Last | " | | | 18. Mother's Name | e (First, Middle, I Marie Mu | • | |
| Z Z | 2 should and Mer is marke aumatic | 은 | Rudolph Rodkey 19a. Informant's Name/Relationship | (Type Print) | 19h Maili | na Address (Street | | | r, City or Town, State, | Zin Code) |
| | and 2 sho ealth and n 27 is m | | Mr. Gregory Witm | ** | <u> </u> | Chesapea | | | e, Marylar | · · · · · · · · · · · · · · · · · · · |
| ore, | of Health of Health fitem 27 | | 20a. Method of Disposition | Damauel from State | 20b. Place of Dispo cemetery, cre | osition (Name of matory or other place | ce) | Date | 20c. Location - City of | r Town, State |
| Baltimore, | Ement of tant: If ignry or | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🎇 Other (<i>Speci</i> | | Oak Law | n Cemeter | cy 2/2 | 2/2008 | | , Maryland |
| Bal | permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once. | | 21. Signature of Funeral Service Lice | nsee | 2 | | | | Dundalk, Maryland 2 | |
| | | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that caused the | e death. Do not en | ter the mode of dyir | ng, such as cardiac | or respiratory arr | rest, | Approximate Interval Between Onset and Death |
| a | Physician | 80 Y | Immediate Cause (Final disease or condition | . Deb | lity | | | 1. | 1-1 | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or es a | consequence of): | ation | | ec/ | also. | 7 months |
| | R (1) | e. | Securations list conditions if any leading to immediate | b. Due to (or as a c | | cture | 1 -000 | N / W | AKA | a months |
| | uted d ansit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | | 1764 | / Kus | 0101 | |
| o, | tificate be executed g physician and as the burial-transit | | that initiated events resulting in death) Last | Due to (or as a o | consequence of): | | | X | X | |
| 68760, | ate be hysici | edical | | _d | | | | Mr. Hr | | |
| | | | IF FEMALE: | | | | 1/4 | 13 | | |
| P.O. Box | The law requires that the death cert ite has been signed by the attending age 2 should be detached for use a | Physician/M | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 23c. If yes, outcome pf 1□Live birth 2 4□Pregnant at tir 9□Unknown | Fetal death 3 | ⊒Ectopic pregnancy ⊒ Other <i>(specify)</i> _ | | n. | 23d. Date of de Month | elivery Day Year |
| S, D | s that gned b | y Pl | Part II. Other significant conditions | , " | not resulting in the u | ınderlying cause giv | en in Part I. | 23e. Did tol | bacco use contribute t | to the cause of death? |
| ord | equire en siç ould t | pa | LETT NIP F | racture | | | | 1 □ Y | es 2□No 3□F | robably 4 Munknown |
| Division or Vital Records, | has be | Completed by | Osteoporos | , 2 | | | - | 24a. Was a autops | sy prior to | utopsy findings available completion of cause of |
| E H | : The cate I | Sol | | | | | | perform 1∐ Yes | med? death? 2 No 1 ☐ Ye | |
| Zi Zi | sician: Th certificate rector, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | nt 3 DOA Oth | 26. Place of Deat | | | |
| ō | Phys ral di | 5 | 1 Yes 2 No 27. Manner of Death | 1 ☐ Inpatient 28a. Date of Injury | ER/Outpatie | III 3 DOX | 4 LI Nursing Ho | | ence 6 Other (Sp. ow injury occurred | ecify) |
| on | Attending Physician: r death. ector: After this certific by the funeral director, | tion | 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio | (Month, Day') | | P M Wor | k? Yes 2∭KNo | + PPDE | | clothes |
| Vis | r Atte er dea recto by th | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined | e 290 Place of injun | - At home, farm, st | - | | 28f. Location (Si City or Town | treet and Number or F | Rural Route Number, |
| | ital ol Irs afti ral DI | | | Home | | | | 70/7 | -heserpeak | - |
| | To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page | Medical | | nysician: To the best of miner: On the basis of e and manner state | xamination and/or ir | | | | | |
| | To the within To the comple | Me | 29b. Signature and title of certifier | | | 29c. Licens | | 2 | 29d. Date signed (Mor | |
| | | | · elle XX | MO | | Doog | 3850 | | 2/20/08 | |
| 1 | 37 | | 30. Name and eddress of person who 9101 Franklin 59 | vale Drive | Surte 20: | | HIM, MD | 21237 | 7 | |
| rij | Sta Registr | | 31. Date filed (Month, Day, Year) FEB 2 1 200 | 32. Registrar | s Signature | dis. | | | | |
| - | | _ | | | | | | | | |

| | | | For State Registrar | State of M | laryland | | artment of F rtificate of | | | giene Reg. No. 2 | 801 | 05296 | | | |
|----------------|---|--------------|--|--|--------------------------------|--------------------------------|--|---|---------------------------------------|----------------------------------|--|---|--|--|--|
| Ħ | Physicia | an | 1. Decedent's Name (First, Middle, L. | | | | | | 2. Date of De Month | Day | Year | 3. Time of Death | | | |
| | /Medic Examin | al | 4a. Facility Name (If not institution, gi | Helen | | Waugh | 4b. City. Town, o | r Location of Dea | Februa | | 2008 y of Death | 10:20 P ^M | | | |
| | Examin | eı | 3 Brown Cone Ga | | , | | | tingham | | | Ltimo | re | | | |
| | Funeral Director | | | Sex 7. A | ge (In yrs. li 72 | ast birthday) Yrs. | If Under 1 Year Months Days | If Under 24 Hrs Hours Min | 8. Date of Bir (Month, Da Oct 2 | th ly, Year) 4,1935 | Cour | place (State or Foreign ntry) ryland | | | |
| | and ww | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | , Town or Lo | cation | | | - | 1 | 10d. Inside City Limits | | | |
| | Maryla | to | Maryland Balti | more | | Noti | ingham | | | | | 1 ☐ Yes 2 ☐ No | | | |
| | th the | Director | 10e. Street and Number | | | 11021 | 10f. Zip Code | | | 10g. Citizen of What Country? | | | | | |
| | s 23a | | 3 Brown Con | | | | 212 | | | U.S.A. | | | | | |
| 30 | y within 72 hours after death with the Maryland yiene. r than "natural", or items 23a or 23a-f show the Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates: | ? No | | Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No | lispanic Origin? (: an, Mexican, Pue Specify: | Specify Yes or No rto Rican, etc.) | | ce - Americ ack, White, <i>fy:</i> Whi | etc. | | | |
| 2-003p | 72 hou natura lical E | | 15. Decedent's E (Specify only highest g | iducation | Ţ | 16a. Dece | dent's Usual Occup | ation | orkina | 16b. Kind of Business/Industry | | | | | |
| Z | | Completed | Elementary/Secondary (0-12) | College (1-4or | 5+) | | kind of work done DO NOT use retire | d) | nning | | | | | | |
| N D | e filed within al Hygiene. I other than ' vent, the Me | ပ္ပ | 12 years 17. Father's Name (<i>First, Middle, Las</i> | t) | | Wai | tress | 18. Mother's Na | me (First, Middle | | | Seafood | | | |
| yland | should be and Mental s marked o | To Be | Pau1 | Skag | gs | | | lian | | • | Miller | | | | |
| Mary | | | 19a. Informant's Name/Relationship | | | 1 | ng Address (Street | | | | | , | | | |
| e) e | ges 1 and 2 t of Health if item 27 i or other tra | - 1 | Michael Conroy · | - Son | 20b PI | | 5 Che1se | y Avenue | Baltin Date | ore, MI | | | | | |
| E E | 0 0 - 1 | | 1 Surial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec | | CE | əmetery, crei | natory or other pla of Faith | · i | . 23,200 | | • | · | | | |
| Dalt | permit. Pag Department Important: ii any injury o | | 21. Signature of Funeral Service Lice | | 0 | | 2. Name and Addre | | | | | - | | | |
| מ | 89588 | | faul Z. L | arton | to | I | eonard J | . Ruck, | Inc. 53 | 05 Harf | | | | | |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ear hire. Approximate prevail Betwee constitution as mylastatic cancer to brain unknown a. mylastatic cancer to brain unknown a. mylastatic cancer to brain unknown | | | | | | | | | | | | |
| , | Physician /Medical | | disease or condition resulting in death) | a. TYLMOS Due to (or as | | | Ker to | Drair | אורש ביונט | imar | N A | Q welks | | | |
| | Examiner | | Sequentially list conditions | h | | | | | 00 | 100 201 | 7 | | | | |
| - | pe tis | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury | | | | | | | | | | | | |
| | execut and al-tran | Examiner | that initiated events resulting in death) Last | c Due to (or as | s a consequ | quence of): | | | | | | | | | |
| 00/00 | ficate be executed physician and s the burial-transit | edical | d | | | | | | | | | | | | |
| _ | certifica Iding ph | Medi | IF FEMALE: | | | | | | | | | | | | |
| 20 20 20 | sician: The law requires that the death certific certificate has been signed by the attending prector, page 2 should be detached for use as | Physician/M | 23b. Was decedent pregnant in the past \$\square\$ months? | 23c. If yes, outcome 1☐Live birth 4☐Pregnant | 2 ☐ Fetal | death 3[| Ectopic pregnanc Other (specify) | у | | 23d. Date of Month | | ery Day Year | | | |
| 5 | the d | hysic | 1 Yes 2 No 9 Unknown | 9□Unknown | at time of de | 54III 3 C | | | | | | | | | |
| ν̈́ L | law requires that the as been signed by the 2 should be detache | by P | Part II. Other significant conditions | | but not resu | itting in the u | nderlying cause giv | en in Part I. | 23e. Did | obacco use coi | ntribute to t | he cause of death? | | | |
| cords | requir een si hould I | | CUI CIPIOITI | atous / | JUI | 1119 | 1115 | | 1 🗆 | Yes 2 No | 3 ☐ Prol | bably 4 Unknown | | | |
|) | The law ate has b | Completed | | | | | | | 24a Was | | | opsy findings available ompletion of cause of | | | |
| ō | an: TI tificate tor, pa | a) | 25. Was case referred to medical | 1 | | | | 26 Place of Bu | 1 Yes | 2 No | 1 ☐ Yes | 20 No | | | |
| _ | Physician: r this certific ral director, | To B | examiner? 1 Yes 2 No | Hospital: 1 ☐ Inpat | ient 2 □ I | ER/Outpatier | nt 3 DOA Oth | | | dence 6 🗆 O | ther (Specia | fy) | | | |
| SION OF | nding Plath. | 7 | 27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation | 28a. Date of Inj (Month, D | ury ay Year) | 28b. Time o Injury | Wor | ry at ·k? Yes 2 □ No | 28d. Describe | how injury occu | irred | | | | |
| 2 | al or Atte s after des il Directo d in by th | Certificatio | 3 ☐ Suicide 6 ☐ Could not determined | J Zoe, Flace of it | njury - At ho etc. (Specify | me, farm, str | eet, factory, office | | 28f. Location (City or To | Street and Nurr wn, State) | ber or Rur | al Route Number, | | | |
| | To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | edical (| 29a. Certifier 1 Sertifying F (Check only one) Medical Example | Physician: To the bes aminer: On the basis and manner s | of examinat | wledge, deat tion and/or in | h occurred at the ti vestigation, in my | me, date and plac opinion, death oc | ce, and due to the | cause(s) and r date and place | nanner as s e, and due t | stated. to the cause(s) | | | |
| | To th Withir To th comp | Me | 29b. Signature and title of certifier | 20 11. | .1 | | 29c. Licens | se number | , | 29d. Date sign | ed (Month, | Day, Year) | | | |
|) | ~~ | | 1 Stoher | J. HU | Me | | NA | 10811 | <u> </u> | 213 | 0/2 | ~6 | | | |
| | 0 | | 80. Name and address of person who | completed cause of | death (Item | 28a) (Type, | Print | PR. Sui | TE 30% | 7 Tows | SON | MDZIZOY | | | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 1 2008 ^{32. Flegis} | trar's Signa | ture | good) | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b, perfH, 8877, 3/5/08 TT
State of Maryland / Department of Health and Mental Hygiene
amend #11 Per FH G876 2/21/08 efficate of Death

Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2.09AM 2008 Wallace 02 08 Carrie /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTINDRE WASHIWITON IN EDICAL CENTER
5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthda) ANNEARUNDE GLEN BURIF If Under 1 Year If Un 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) State or Foreign **Funeral** Months Min. Days Hours 1 □ M 2 🗓 F 41 216-36-0960 08 09 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland r 28a-f show notified at 10a. State 10b. County X□Yes 2□No Funeral Director Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 7 U.S.A. 21225 1021 Renick Ct. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. items 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes X☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2XXMarried 0, Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Black þ 3 ☐ Widowed + Diverced "natural" Completed Ith and Mental Hygiene.
27 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 4yrs Elementary/Secondary (0-12) State of Maryland Secretary 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lillian King Percy Wallace ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10 Midwood Street, Brooklyn, NY 11225 permit. Pages 1 and 2.
Department of Health a
Important: If item 27 is
any injury or other trau Linda Wallace-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2/28/2008 2/18/08 Baltimore, Md 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service Lic nsee 21215 4300 Wabash Ave, Baltimore, PSIN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Carola migo /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. been signed by the a should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part IL Other significant conditions contributing to death but not resulting in the underlying gause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 1☐ Yes 2 **X**No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Manpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No ٩ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death I Director: After t d in by the funera Medical Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours af

To the Funeral D

completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of co 238958 30. Name and address of the son who completed cause of death (Item 23a) (Type, Print) Try hway Sw alen Burne

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

(ear

208

Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year) 2008

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Manh

Revolension

21134

Physici /Medic Examir

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Edna Washinston

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

Sta Regist DHMH 17 Rev 1/2

| | Please Type or Print in | | | • | | | | | | |
|------------------------|---|--|---|---|---|----------|--|--|--|--|
| | State of Maryla | | ment of Health and N iicate of Death | | 2000 000 | 299 | | | | |
| | 1. Decedent's Name (First, Middle, Last) | Certii | icate of Death | Reg. N | 3. Time of D | Death | | | | |
| an al - | Edna Mae | | Washington | Tebury 1 | 4 2008 0130 | | | | | |
| er | 4a. Facility Name (If not institution, give street and number) Sinui Hospital & Bultir | nove | D. City, Town, or Location of Death Baltimore Under 1 Year If Under 24 Hrs. | | c. County of Death 9. Birthplace (State or | Foreign | | | | |
| | 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs 212-34-7217 Usual Residence of Decedent | 9. Birthplace (State or Country) MI | _ | | | | | | | |
| 'n | 10a. State 10b. County 10c. C | 10d. Inside City | | | | | | | | |
| Director | MD NA 10e. Street and Number | Balti | Of. Zip Code | 100.0 | Citizen of What Country? | | | | | |
| Ξ | 4541 Lanier Ave | | 21215 | log. | U.S.A. | | | | | |
| nera | 11 Marital Status 12. Was Decedent Ever in | U.S. 13. Was | Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto | pecify Yes or No- | 14. Race - American Indian, | | | | | |
| Completed by Funeral | Armed Forces? 1 ☐ Never Married | | Yes 2 No Specify: | o Hican, etc.) | Black, White, etc. Specify: Black | | | | | |
| pleted | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) | (Give kind life. DO | 's Usual Occupation of of work done during most of work NOT use retired) | | Kind of Business/Industry | | | | | |
| Com | 12th grade lyr | Dat | a Processing | | Hospital | | | | | |
| Be | 17. Father's Name (First, Middle, Last) | | | ne (First, Middle, Maide | • | | | | | |
| မ | Edward Davis 19a. Informant's Name/Relationship (Type. Print) | 10h Mailing A | ddress (Street and Number or Ru | ine Thomp | | | | | | |
| | Kathy Douglas-Daughter | | Pimlico Road, | | | | | | | |
| | 20a. Method of Disposition 20b. | Place of Disposition | on (Name of | | Location - City or Town, State | | | | | |
| | 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | | orial Park 2/ | 22/08 Ra | andallstown, M | мd | | | | |
| | 21. Si na re of Funeral Service Licensee | Marc | ame and Address of Facility Ch F/H West D Wabash Ave, | | e, Md 21215 | | | | | |
| | 23a. Part I. Enter the disease, or complications that caused the deshock, or head failure. List only one cause on each line. | | | | Approximate Interval Betw | veen | | | | |
| | Immediate Cause (Final disease or condition | Obstruct | · S D lane | Diserse | Onset and D | eath | | | | |
| | resulting in death) Due to (or as a conse | | 0 | | | | | | | |
| - | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or Injury Sequentially list conditions, Due to (or as a connequence of): Cause (Disease or Injury) Sequentially list conditions, Due to (or as a connequence of): Cause (Disease or Injury) | | | | | | | | | |
| Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | Harry | Failure | | | | | | | |
| Еха | resulting in death) Last Due to for as a conse | equence of): | 10011-10 | | | | | | | |
| ical | d | | | | | | | | | |
| Med | IF FEMALE: | | | | | | | | | |
| Physician/Medica | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | etal death 3 □Ec | topic pregnancy her (s <i>pecify</i>) | | 23d. Date of delivery Month Day Year | | | | | |
| Ph | Part II. Other significant conditions contributing to death but not re | esulting in the unde | rlying cause given in Part I. | 23e. Did tobacc | o use contribute to the cause of de | eath? | | | | |
| Completed by | | | | 1 □ Yes | 2 No 3 Probably 4 | nknown | | | | |
| olete | | | | 24a. Was an | 24b. Were autopsy findings a | vailable | | | | |
| mo | | | | autopsy performed: 1 Yes 2 🔀 | prior to completion of ca death? 1 ☐ Yes 2 ☐ Yo | use or | | | | |
| Be | 25. Was case referred to medical examiner? | | | th (Check only one) | | | | | | |
| 2 | _ X | ER/Outpatient | | ome 5 Residence | | | | | | |
| ion: | 1 Matural 5 Pending (Month, Day Year) | Injury | 28c. Injury at Work? M 1 □ Yes 2 □ No | 28d. Describe how in | jury occurred | | | | | |
| rtifical | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At building, etc. (Spec | home, farm, street, | | 28f. Location (Street City or Town, St | and Number or Rural Route Numb ate) | ber, | | | | |
| Medical Certification: | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my king the desired form one and manner stated. | | | | |) | | | | |
| Me | 29b. Signature and title of certifier | | 29c. License number | 29d. [| Date signed (Month, Day, Year) | | | | | |
| | 1 July | | RES OC | U F | har le du | 14 | | | | |
| | 30. Name and address of person who completed cause of death (It | em 23a) (Type, Prir | nt) 0 0 1 | 1/6 | 7 / | | | | | |
| | Jose Murey Sinai F | lospital | of Dultin | nove | | | | | | |
| te ar | 31. Date filed (Month, Day, Year) 32. Registrar's Sig | nature | K a | | | | | | | |
| 001 | FEB 2 1 2008 | The state of the s | / | | | | | | | |
| | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

| | | | State of Maryland | • | artment of H rtificate of L | | , , | 20 | 100 05300 | | | |
|-------------|--|----------------|--|-----------------------|---|---|---------------------------------|-----------------------------|---|--|--|--|
| | | | Registrar 1. Decedent's Name (First, Middle, Last) | Cer | unicate of L | Jealli | 2. Date of Dea | Reg. No. 💆 🔱 | 3. Time of Death | | | |
| | Physici | an | | | | | _Month | Day Year | | | | |
| Pin. | /Medio Examin | | Mina Mae Wright 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or | | -EB | `` | 18 208 >:13 A M | | | |
| | EXAMIN | ei | Future Care Chesape ak e | | Arnold | | | | Arundel | | | |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. las. | t birthday) | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birti (Month, Day | | Birthplace (State or Foreign Country) | | | |
| L | Director | | 215-12-4843 1 M 2 St 86 | Yrs. | World bays | riouis Willi. | 09-01- | -1921 | PA | | | |
| | and w | | Usual Residence of Decedent 10a. State 10b. County 10c. City, T | own or Lo | cation | | | | 10d. Inside City Limits | | | |
| | Aaryla F sho | 5 | 7 | en Bu | | | | | 1 Yes 2 X No | | | |
| | the N 28a-I | Director | 10e. Street and Number | CII Du | 10f. Zip Code | | | 10a. Citizen of | What Country? | | | |
| | a or st pe | Ä | 36 1st Ave | | 21060 | | | U.S.A | | | | |
| | death ms 2 | Funeral | 11 Marital Status 12. Was Decedent Ever in U.S. | 13. | | spanic Origin? (Spe n, Mexican, Puerto I | cify Yes or No- | | ce - American Indian, | | | |
| 36 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | þ | Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No If Yes, Give Year or Dates: | | Tes, specify Cuba I ☐ Yes 2 <mark></mark> No | Specify: | Rican, etc.) | | ack, White, etc. ry:white | | | |
| 215-0036 | 2 hou atura cal E | ted | | 16a. Deced | lent's Usual Occupa | ation | | 16b. Kind of B | Business/Industry | | | |
| 212 | hin 7. e. an "n Medi | Completed | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) | (Give life, L | kind of work done d DO NOT use retired, | luring most of workir) | ng | | | | | |
| 7 | ed wit | S | Elementary/Secondary (0-12) College (1-4or 5+) | Facto | ry Worker | | | | Service | | | |
| Maryland | be file tal Hy d oth | Be | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Name | | | me) | | | |
| <u> </u> | ould I Men narke | မှ | unknown | | | Helen Br | | | | | | |
| <u>a</u> | 12 sh hand 7 is π trauπ | | | | • | and Number or Rura | | | | | | |
| | 1 and Health em 27 Ither tr | | Mrs. Linda Arvey / daugther 20a. Method of Disposition 20b. Plac | e of Dispo | sition (Name of | Drive; Gl | en Bur | | - City or Town, State | | | |
| و | Pages nent of int: If its iry or o | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State | etery, crer | natory or other place | í i | 2000 | | | | | |
| Baltimore, | nit. Partme ortan Injur | | Pro-estation of | | | ry 2-22- | | | lyn Park, MD & Cremation | | | |
| ñ | permit. Departr Imports any Inj | (| Inature of Funeral Service Licensee W009/8 | | | | | | nie, MD 21061 | | | |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| | Physician | i | Immediate Cause (Final disease or condition a. CORONAR | y / | ARTERY | DISE | ASE | | Onset and Death | | | |
| | /Medical Examiner | | resulting in death) Due to (or as a consequer | | | | | | | | | |
| | xammor | 7 | Sequentially list conditions, if any, leading to immediate Due to or as a consequent | nce offi | | | | | | | | |
| | rted nsit | nin | cause. Enter Underlying Cause (Disease or injury that initiated events c | 100 011 | | | | | | | | |
| | execunand ial-tra | Examiner | resulting in death) Last c Due to (or as a consequer | nce of): | | | | | | | | |
| 8/60, | ficate be executed physician and sthe burial-transit | dical | d | | | | | | | | | |
| ט | rtifica ng ph as th | ledi | | | £ | | | 1 | | | | |
| X R R | death certif e attending d for use as | an/N | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal de | | Ectopic pregnancy | | | | ate of delivery lonth Dav Year | | | |
| 5 | at the death certific by the attending particulary is | Physician/Me | in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 1 □ Yes 2 No 9 □ Unknown | | Other (specify) | | | M | lonth Day Year | | | |
| 7 | law requires that the as been signed by th 2 should be detache | | Part II. Other significant conditions contributing to death but not resulting | ng in the ur | iderlying cause give | en in Part I. | 23e. Did to | bacco use con | ntribute to the cause of death? | | | |
| Hecords, | quires n sign ald be | d by | CONGESTIVE HEART FAILL | 12E | | | 1 🗆 \ | es 2 No | 3 ☐ Probably 4 ☐ Unknown | | | |
| င္ပ | w require s been sign should b | lete | PNEUMONIA | | | | 24a. Was | an 24b. | . Were autopsy findings available | | | |
| 2 | sic ian; The law certificate has t irector, page 2 s | Completed | 770,077 | | | | | rmed? | prior to completion of cause of death? 1 ☐ Yes 2 ☐ No | | | |
| VItal | ian: rtifica tor, p | Be C | 25. Was case referred to medical | | | 26. Place of Death | 1□ Yes (Check only o | 2 No | TI res 2 No | | | |
| | <u> </u> | To E | examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER | /Outpatien | t 3□ DOA Othe | er: 4 Nursing Hon | ne 5 ☐ Resid | lence 6 □Ot | her (Specify) | | | |
| n 0r | ding Ph n. After th funeral | | 27. Manner of Death 28a. Date of Injury 28 (Month, Day Year) 28 (Month, Day Year) | 3b. Time of Injury | 28c. Injury Work | at 2 | 8d. Describe h | ow injury occu | rred | | | |
| S 10 | tendi eath. tor: A the fu | cati | 2 Accident investigation | | | /es 2 □ No | | | | | | |
| UNISION | or At after d Direc in by | Certification: | 4 Homicide determined 28e. Place of injury - At home building, etc. (Specify) | e, farm, str | eet, factory, office | 2 | 8f. Location (S City or Tow | Street and Num m, State) | ber or Rural Route Number, | | | |
| | spital ours a neral filled | | 29a. Certifier 1 ertifying Physician: To the best of my knowle | edae, death | occurred at the tim | ne, date and place, a | and due to the | cause(s) and m | nanner as stated | | | |
| | ne Hos | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and manner stated. | and/or in | estigation, in my or | oinion, death occurre | ed at the time, | date and place | , and due to the cause(s) | | | |
| | To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral or the fu | Me | 29b. Signature and title of certifier | | 29c. License | | | 29d. Date signe | ed (Month, Day, Year) | | | |
| } | ~ | | I hisnegi mis | | D5 | 7531 | | FEB | 12,2008 | | | |
| 1 | (0) | | 30. Name and address of person who completed cause of death (Item 23 | Ba) (Type, | Print) | | | | | | | |
| 9 | <i>y</i> | | 31. Date filed (Month, Day, Dear) FEB 2, 1, 2008 | Hu | 7, Suil | i 204, | mille | rsville | - MD 41108 | | | |
| | Sta Registr | _ | 31. Date filed (Month, Day, Year) 32. Registrar's Signatur | - | | - | | | | | | |
| | nogiali | ar | FEB 2 1 2008 | STATE OF | (Lange | | | | | | | |

DHMH 17 Rev 1/2001

| | | | For State Registrar | State of | f Marylar | | artment of rtificate of | | Mental Hy | giene Reg. No. | 08 | 053 | 0 |
|---------------------------------|--|---------------------------|--|---------------------------------------|---|------------------------|---|-------------------------------|--|------------------------------|---------------------------|---|-----------|
| | Physici | | 1. Decedent's Name <i>(First, Middle, Last)</i> Jackie Lynn Yakubowski | | | | | | 2. Date of De Month Febru | nath | 20 08 | 3. Time of 1 12:02 | |
| 0 | /Medic Examin | | 4a. Facility Name (If not institutio | | | | | or Location of De | | 4c. Coun | ty of Death | 1 | |
| | Funeral | | GREATER BALTIM 5. Social Security Number | 6. Sex | 7. Age (In yrs. | | If Under 1 Yea | | rs. 8. Date of Bit | | 9. Birthp | ace (State or | r Foreign |
| | Director | | 212-52-6614 | 1□M 211 F | 59 | Yrs. | Months Days | Hours Mi | rs. 8. Date of Bir in. (Month, Da June 1 | 5,1948 | Mary | "land | |
| (5) | ehow | | Usual Residence of Decedent 10a. State 10b. County | <u> </u> | 10c. Cit | y, Town or Lo | cation | | | | 1 | 0d. Inside Cit | |
| ~ | e Man | ctor | Maryland Balti | more Count | У С | ockeys | ville | | | | | 1 🗌 Yes | 2 No |
| C | with the M s or 28a-f | Dire | 10e. Street and Number 10102 Woodlake | Drive Ant | - 7\ | | 10f. Zip Code | 21030 | | 10g. Citizen of United | | - | |
| Backie | after death with the Maryland or Items 23a or 28a-f ehow role of most by notified at | Funeral Director | 11. Marital Status | 12. Was Dece | dent Ever in U | .S. 13. ¹ | | | (Specify Yes or No erto Rican, etc.) | | ce - Americ | an Indian, | |
| 036 | be filed within 72 hours after death with the Maryla lat Hygiene. Id other than "natural", or items 23s or 28s-f ehor event, the Medical Examirat intest by notified at | þ | 1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 🚰 Divorced | IL Van Cir | 2 (₫No 8 | 1 | fYes, specify Cu 1 □ Yes 2 ☑ N | | erto Rican, etc.) | Spec | ack, White, o | otc. √hite | |
| 不管 | n 72 ha "natu edical | Completed | 15. Deceder (Specify only highe | nt's Education st grade completed) | | 16a. Dece (Give | dent's Usual Occi kind of work don DO NOT use retir | upation e during most of w | vorking | 16b. Kind of | 3usiness/Inc | dustry | |
| 35 | d within giene. er then " | omo | Elementary/Secondary (0-12) | College (1 N/S | -4or 5+) l | | Receptio | | | Valle | y View | v Farms | 3 |
| 1 land | should be file nd Mental Hy marked oth matic event, | To Be (| 17. Father's Name <i>(First, Middle,</i> Conrad Matterso | | | | | | lame (First, Middle Matters | | me) | | |
| J b | afth a | | 19a. Informant's Name/Relations Miss Kristi N. | | .(Dau.) | | | at and Number or ke Drive | Rural Route Numb | | | code) Le,MD21 | 1030 |
| a K | Pages 1 ar nent of Hea int: If Item iry or other | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5 | | . (| cemetery, crer | sition (Name of matory or other pi neral Ch | ace) apel Feb | Date .21,2008 | 20c. Location Fores | | | yland |
| Balti | permit. Pages Department of Important: If I any injury or o | | 21. Signature of Funeral Service | Licensee Gav | 2/2 | P\ 22 | Name and Add | Alternat Road | ives Fundiu | eral&Cr | emati? | nostr. | .,P.A. |
| -3 | | | 23a. Part . Ent r the di lease, o shoot, or heart failure. Lis | | | | | | | | | Approximate Interval Betw Onset and D | ween |
| | /Medical | | Immediate Cause (Final disease or condition resulting in death) a. Cotonary artery or pulmonary embolic event Due to (or as a consequence of): b. Encl stage Renal Disease on Henodialysis prob 2 Diabets To any, leading to immediate cause Forter Indeptions Due to (or as a consequence of): Mellifus | | | | | | | | | | |
| | Examiner | Jer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. End S | tage R | enal Dis | sease on l | temodialg | sis prob 2" | Diabet | is . | ~3 % | ซาการ์ |
| K | be executed sicien and burial-transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | 1 a Meja | | Colon | cancer | | | | | VImo | nth |
| 8760, | the the | dicai | | a Coro | naryo | | disease | with cor | igestive | neart f | ailure | ~3 | years |
| J. Box 6 | Attending Physicien: The law requires that the death certific ir death. If death. ector: After this certificate has been signed by the eltending p by the funeral director, page 2 should be detached for use as | Completed by Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown | | irth 2 ☐ Feta ant at time of d | ancy Il death 3 | Ectopic pregnan Other (specify) | 18 01 | , | | ate of delive | - | Year |
| Division of Vital Records, P.O. | res that the de igned by the be detached | by Phy | Part II. Other significant conditi | ons contributing to de | ath but not res | ulting in the u | nderlying cause g | liven in Part I. | | tobacco use co | | ne cause of de | |
| corc | w requi | leted | | | | | | | 24a. Was | Yes 255No | | | |
| E Re | The la | Comp | | | | | | | auto | psy ormed? 2 No | prior to condeath? 1 Yes | psy findings a mpletion of ca 2 No | ause of |
| Vita | sicien: certific rector, | Be | 25. Was case referred to medica examiner? | | | | | thor | eath (Check only | | | | (1) |
| n of | ng Phys fter this ineral di | on; To | 1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pendi | 28a. Date o | npatient 2 of Injury h, Day Year) | 28b. Time of Injury | I 3 DOA | 4 Nursing | Home 5 ☐ Res 28d. Describe | how injury occi | | r) | |
| visio | To the Hospitel or Attending Physicien: The law requires tha within 24 hours efter death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be de | Certification; | | gation | | ome, farm, str | M 1 [| Yes 2 No | | Street and Nur wn, State) | nber or Aura | al Route Num. | ber, |
| Di | pitel or ours efter oral Dir filled in | | | ng Physician: To the | | | | | | | | tatad | |
| | the Hos tin 24 ho the Fun | Medical | (Check only 2 Medical one) | Examiner: On the ba and mann | isis of examina | ition and/or in | vestigation, in my | opinion, death or | ccurred at the time, | date and place | , and due to | o the cause(s) |) |
| | 5 × 5 × 5 × 5 × 5 × 5 × 5 × 5 × 5 × 5 × | 2 | 29b. Signature and title of certific | Niman | na | | 100 | nse number | 000 | 29d. Date sign | ed (Month, | Day, Year) | |
| | 2 | | 30. Name and address of person | who completed cause | e of death (Iter | n 23a) (Type, | | 065 | es Sti | D. 11 | 8/00 | MD 2 | 7.7-11 |
| | Sta | te | 31. Date filed (Month, Day, Year, | 11/00 n D, V | gistrar's Signa | ature (0 | 101 N | . Charl | セク ントレ | Ugli | mult, | , U. | 11209 |
| | Registr | | FFB2 | 1.0 | Elen . | N. A | and a | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 02 CLARENCE ABERCROMBIE 09 08 10:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Nov 15, 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months 1946 1 M 2 F 490-50-1865 61 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h Count permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. Ridgeley WV Mineral 1 ☐ Yes 🛂 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 26753 USA Rt. 2 Box 365 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ↑☐ Yes 2 ☐ No If Yes, Give Year or Dates: Vietnam 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married Ž☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: black 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) US Marine Corp **MSGT** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Roosevelt Abercrombie Archie Lee Brown ဥ 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Rt. 2 Box 365 Ridgeley WV 26753 19a. Informant's Name/Relationship (Type. Print, Lyn Abercrombie wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Quantico National Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 2/19/2008 Triangle VA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service kicensee 22. Namescarbeili Füneral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disea shock, or heart failur e, & complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause of a ach line. Approximate Interval Between Onset and Death Imm Jiate Cause (Fin **Physician** dise se or condition re Illing in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 3 □ Probably 4 □ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) No. 1 Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 □ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

after death within 24 hours a To the Funeral I

State

Medical

29a. Certifier

31. Date filed (Month, Day, Year)

FEB

and manner stated.

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month. Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Dav **Physician** Richard Collier Alford February 06, 2008 11:45 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F Director 220-34-3194 Washington, D.C. 70 January 28, 1938 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hyglene. and the frem 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show uny or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Lusby Maryland Calvert 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 20657 United States 50 Appeal Lane, Apt. 220 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1956–1960 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Bus Driver School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Delis Collier Alford Helen M. Manco 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) June Diane Alford / Wife 50 Appeal Ln., Apt. 220, Lusby, MD 20657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Department or Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Cremetory 02/07/2008 Alexandria, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. P.O. Box 600, Lusby, MD 20657 23a. Part1. Enter the diseast, or conflictions that caushock, or heart failure. List only one cause on ear Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, reading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 5 Other (specify) been signed by the a should be detached f 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 es 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ٩ 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 DeMatural after death.

I Director: A din by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day,

FEB

8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1ASK

32. Registrar's Signature

Abou

29c. License number

| 12 Research Analyst Committee | | | | 1 - State of Ma State Registrar | ryland. | | artment of F tificate of I | | | glene 200 | 8 05304 |
|--|--------------|------------------------------------|-------|---|-----------------------------|---------------|--|--|----------------------------------|----------------------------------|---------------------------|
| Stuburhan (Depot at all 1900 and a consequence of the control of t | | Physicia | an | | | | | | Month | Day Vos | ar . |
| Suburban Hospital Suburban Hosp | | | | | | | 4b. City, Town, or | Location of Death | reb. 5, | | |
| 190-18-6.256 Substitute S | | LAU | | Suburban Hospital | | | Ве | thesda | | Montgo | mery |
| 190-18-6254 Washington; D.C. Total Court Total Cou | | | 5 | - T | (In yrs. last | | | | 8. Date of Birth (Month, Day | 9. E | Country) |
| 150. State 150. Courty 150. State 150. Courty 150. State 150. Courty 150. State | 1.00 1.00 | Director | | 190-18-6254 | 84 | 118. | | | Jan. 22 | ,1924 P | ennsylvania |
| Continue of the continue of | | /land low at | | | 10c. City, T | own or Lo | cation | | | | 10d. Inside City Limits |
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| Continue of the continue of | | or 28 | Dire | 10e. Street and Number | | | | | 1 | 10g. Citizen of What | Country? |
| Continue of the continue of | | ath w | | | | | | | | | |
| Continue of the continue of | | ter de items | nne | Armod Forces? | | _ 13. V | Was Decedent of H f Yes, specify Cuba | ispanic Origin? (Sp in, Mexican, Puerto | ecify Yes or No- Rican, etc.) | | |
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| 4. Concation S Corner (Specially) 22. Signature of Pinneral Service Literatory 22. Name and Address of Pacility DeVol Funeral Home 22.22 Wisconsin Ave., N.W. Washington, D.C. 20007 Agrorimental model of Spring and Ave., N.W. Washington, D.C. 20007 Agrorimental models of Pinneral Service Literatory 22. Septimental for the Conception of | \geq | shoul nd Me mark | ř | | | 19b. Mailin | ig Address (Street | | | | e, Zip Code) |
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| 222 WISCOIDS III AVE., N.W. Washington December D | Ě | Pag Iment Iant: I | | | GATE | OF H METER | EAVEN Y | 200 | | | oring, MD |
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| Physician Medical Examiner Page Physician Medical Examiner | | | | | the death. I | | | | | | |
| Due to (or as a consequence of): Due to (or as a consequence of): | | Physician | 10 | Immediate Cause (Final | | | ,··· | 3, | | , | Interval Between |
| Sequentially list conditions, if any, leading to immediate gause garder Underlying and the policy of | | | | resulting in death) | | nce of): | | | | | |
| Due to (or as a consequence of): d | | Examiner | | Conventially list conditions | · | , | | | | | |
| Due to (or as a consequence of): d | | p it | iner | if any, leading to immediate cause. Enter Underlying | ı consequen | nce of): | | | | | |
| The content of the | | ecute and I-trans | xam | that initiated events resulting in death) Last C | consequer | ice of). | | | | | |
| FFEMALE: 236. If yes, outcome pi pregnancy 1 Live birth 2 Fetal death 4 Pregnancy 1 Live birth 2 Fetal death 4 Pregnancy 1 Live birth 2 Fetal death 4 Pregnancy 1 Live birth 2 Fetal death 4 Pregnancy 1 Live birth 2 Fetal death 4 Pregnancy 1 Live birth 2 Fetal death 4 Pregnancy 1 Live birth 2 Fetal death 4 Pregnancy 1 Live birth 2 Fetal death 4 Pregnancy 1 Live birth 2 Fetal death 4 Pregnancy 1 Live birth 2 Fetal death 4 Pregnancy 1 Live birth 2 Fetal death 4 Pregnancy 1 Live birth 2 Fetal death 5 Other (specify) Month Day Year 1 Year 2 No Probably 4 Month Day 4 Month Day 4 | ٦ | be e) | | 330 10 (0) 100 1 | Consequen | 100 01). | | | | | |
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| 25. Was case referred to medical examiner? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner of Death 1 Matural 2 ER/Outpatient 2 E | | v requ | etec | | | | | | | | |
| 25. Was case referred to medical examiner? 1 | Ψ L | he lav e has ige 2 | dmo | | | | | | autop | sy prior 1 | to completion of cause of |
| The state of the s | <u>ra</u> | an: T tificate or, pa | | 25. Was case referred to medical | | | | 26 Place of Deat | | | es 2□No |
| D37891 Feb. 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Rajvanishi, M.D. 121 Congressional Lane #407 Rockville, MD 20852 | > | ysicia is cer direct | 0 8 | | nt 2□ER | /Outpatien | t 3 DOA Oth | | | | pecify) |
| D37891 Feb. 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Rajvanishi, M.D. 121 Congressional Lane #407 Rockville, MD 20852 | 0 | ng Ph fter th ineral | | | | | 28c. Injur Worl | | | | |
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| D37891 Feb. 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Rajvanishi, M.D. 121 Congressional Lane #407 Rockville, MD 20852 | <u> </u> | or At after d Direc in by | il il | determined 20e. Place of Inju | ry - At home . (Specify) | e, farm, stre | eet, factory, office | | 28f. Location (S City or Tow | treet and Number or n, State) | Rural Route Number, |
| D37891 Feb. 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Rajvanishi, M.D. 121 Congressional Lane #407 Rockville, MD 20852 | _ | spital | | 29a. Certifier 1X Certifying Physician: To the best of | f my knowle | edge, death | occurred at the tir | ne, date and place, | and due to the o | cause(s) and manner | as stated. |
| D37891 Feb. 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Rajvanishi, M.D. 121 Congressional Lane #407 Rockville, MD 20852 | | n 24 h | dic | (Check only 2 Medical Examiner: On the basis of | examination | n and/or inv | vestigation, in my o | pinion, death occur | red at the time, o | date and place, and o | due to the cause(s) |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A. Rajvanishi, M.D. 121 Congressional Lane #407 Rockville, MD 20852 | | To ti To ti comp | Me | 29b. Signature and title of certifier | W | 70 | 29c. License | e number | 2 | 29d. Date signed (Mo | onth, Day, Year) |
| A. Rajvanishi, M.D. 121 Congressional Lane #407 Rockville, MD 20852 | 1 | in | | - dums | | | D37 | 891 | | Feb. 5, 20 | 008 |
| State 31 Date filed (Month. Day, Year) 32 Registrar's Signature | | 10 | | | | | | /07 P : | | 000=5 | |
| Registrar FEB 0 7 2008 Street It Aprile | | Sto | te. | 31. Date filed (Month. Day. Year) 328Registra | r's Signature | e . | | 4U/ Kockv | ille, M | D 20852 | |
| | | | | FEB 0 7 2008 | , K | dos | WE ! | | | | |

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Armstrong, George Cincules

| | | | 1 - For Statemend #3 Per | State of Phy G87 | f Marylan 7 3/04/ | d/Depa | artment of tificate | of Healt of Dea | h and M | lental Hy | giene Reg. No. | 2008 | 05305 | | |
|---|--|-------------------|---|---------------------------|-------------------------------------|------------------------|-----------------------------|---------------------------|---|---------------------------------|--------------------------|--|----------------------------------|--|--|
| no; | A | | Decedent's Name (First, Middle, Last | | | | | | | 2. Date of De | ath | <u>. </u> | 3. Time of Death | | |
| | Physicia | _ | Carmen Argueta | | | | | | | Month January | Day 28 | Year 2008 | 9:35 Pm | | |
| | /Medic Examin | a care | 4a. Facility Name (If not institution, give | street and nun | nber) | | 4b. City, To | wn, or Locati | ion of Death | | 4c. C | ounty of Deat | h | | |
| | | 8 | Brooke Grove Nu | rsing Hom | e | | | Sandy | Spring | | | Montgo | mery | | |
| | Funeral | | 5. Social Security Number 6. S | ex | 7. Age (In yrs. i | last birthday) | If Under 1 | Year If Un Days Hou | nder 24 Hrs. | 8. Date of Bir (Month, Da | th v. Year) | 9. Birtl | hplace (State or Foreign | | |
| ži. | Director | | 218-06-1331 | □M 2⊠F | 93 | Yrs. | THO TAIL O | rayo 1100 | | July 16 | , 1914 | | Guatemala | | |
| | pu , | | Usual Residence of Decedent 10a. State 10b. County | | 10c City | , Town or Lo | cation | | | | | | 10d. Inside City Limits | | |
| | anyla shov | 'n | | | 100.00 | y, rount of Lo | callon | | | | | | 1 ☐ Yes 2 ₺ No | | |
| | he M 28a-f otifie | Director | Maryland Montg | omery | | | 105 75- 0 | | Spring | | 10- 011- | | | | |
| | with t | | 10e. Street and Number | | | | 10f. Zip C | | | | rog. Citize | en of What Co | - | | |
| | filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or Items 23a or 28a-f show ant, the Medical Examiner must be notified at | Funeral | 18430 Brooke Grov | | edent Ever in U. | S 13 1 | Mas Docodor | 208 | | ooify Von or No | 1/ | U.S. | | | |
| | ter de Item | Ë | 11. Marital Status 1 ☐ Never Married 2 ☐ Married | Armed Fo | rces? | 5. 15. | f Yes, specify | Cuban, Me | xican, Puerto | ecify Yes or No Rican, etc.) | . ' | Black, White | | | |
| 36 | irs af | by F | 3 ☑ Widowed 4 ☐ Divorced | If Yes, Giv Year or Da | /e | | 1⊠ Yes 2□ | No Spe | city: Guat | emalan | 5 | Specify: | Caucasian | | |
| 21215-0036 | 2 hot | pe | 15. Decedent's Ed | | | | dent's Usual (| | | | 16b. Kind | d of Business/ | Industry | | |
| 715 | nin 73 n "n Medi | ple | (Specify only highest gra | de completed) College (1 | -4or 5+) | (Give life. L | kind of work OO NOT use | done during i retired) | most of work | ing | | | | | |
| 21, | d with giene er tha the | Completed | Elementary/Secondary (5 12) | 5+ | , | | Hom | emaker | | | | Own H | Iome | | |
| b | e file al Hy othe vent, | Be (| 17. Father's Name (First, Middle, Last, | ı | | | | 18. M | other's Name (First, Middle, Maiden Surna | | | Surname) | | | |
| <u>Ja</u> | Ment Ment arked | To | Eulogio Arguet | a | | | | | Sefe | erina Lop | ez | | | | |
| an | 12 should be filed within hand Mental Hygiene. 7 Is marked other than "traumatic event, the Mec | | 19a. Informant's Name/Relationship (| Type. Print) | | 19b. Mailir | ng Address (S | treet and Nu | ımber or Run | al Route Numb | er, City or | Town, State, 2 | ?ip Code) | | |
| ≥, | 1 and 2 Health tem 27 I | | Rebecca Rhoden - Da | ughter | 1 | 11760 lace of Dispo | | | | mbia, Mar | | | | | |
| ore | ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Exeminer must be notified at | | 20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ | of er place) | | Date | 20c. Loca | ation - City or | Town, State | | | | | | |
| Ē | Pag tmen tant: jury | | 4 ☐ Donation 5 ☐ Other (Specif | v) | l l | rt Linco | 1n Crem | | 2/11/ | 2008 | Brent | wood, Ma | aryland | | |
| Baltimore, Maryland | permit. Pages 1 am Department of Heal Important: If Item 2 any Injury or other once. | | 21. Signature of Fun all Service Live | sh-Ma | and Crem | ation Maryl | Center and 2085 | 52 | | | | | | | |
| ŀ | | | 23a. Part1. Enter the disease, or com | plications that c | aused the death | | | | | | | | Approximate Interval Between | | |
| | Physician | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Atherosclerotic Cardiovascular Disease | | | | | | | | | | | | |
| 8 | /Medical | | resulting in death) The resulting in death) The resulting in death) Due to (or as a consequence of): | | | | | | | | | | | | |
| li. | Examiner | | Sequentially list conditions. | | | | | | | | | | | | |
| - | ed sit | ine | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (| or as a consequ | uence of): | | | | | | | | | |
| | ecuti and I-tran | Examiner | that initiated events resulting in death) Last | C | or as a consequ | uence of): | e of): | | | | | | | | |
| 8760, | cate be executed physician and the burial-transit | | | | | , | | | | | | | | | |
| 687 | ficate phys s the | gic | | d | | | | | | | | | | | |
| Box (| The law requires that the death certificate has been signed by the attending page 2 should be detached for use as | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant | | come pf <u>pr</u> egna | | | | | | 23 | 3d. Date of del | ivery | | |
| m | death e atte d for | icla | in the past 12 months? 1 ☐ Yes 2 ☐ No | 4□Pregn | oirth 2 □ Feta nant at time of d | | Ectopic preg Other (spec | | | | | Month | Day Year | | |
| P.O. | t the | hys | 9 □ Unknown | 9∐Unkno | own | | | | | | | | | | |
| S, | w requires that s been signed to should be deta | by P | Part II. Other significant conditions of Diabetes | ontributing to de | eath but not resu | ulting in the ui | nderlying cau | se given in P | art I. | 23e. Did t | obacco us | e contribute to | the cause of death? | | |
| ğ | equire en sig | ed t | | | | | | | | 1 🗆 | Yes 2□ | No 3∏Pr | obably XXUnknown | | |
| င် င် | law re | Completed | | | | | | | | 24a. Was | | 24b. Were au | topsy findings available | | |
| æ | The lav | E O | | | | | | | | perfo | ormed? 2 🔼 No | death? 1 ☐ Yes | completion of cause of 2 ☑ No | | |
| <u> ta</u> | sloian: Th certificate rector, pag | Be C | 25. Was case referred to medical | | | | | 26. F | Place of Deat | h (Check only o | | | | | |
| > | Physic this ce al direc | ToE | examiner? 1 ☐ Yes 2 █ No | Hospital: 1 ☐ I | npatient 2 🗆 | ER/Outpatien | it 3□ DOA | Other: | ☑ Nursing Ho | me 5□Resi | dence 6 | □Other (Spe | cify) | | |
| 0 _ | Attending Physician: or death. ector: After this certification in the funeral director; by | Ë | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date (Moni | of Injury th, Day Year) | 28b. Time of Injury | 280 | . Injury at Work? | | 28d. Describe | | | | | |
| Sio | endil eath. or; A | atic | 2 ☐ Accident investigation | <u> </u> | | | М | 1 ☐ Yes | | | | | | | |
| Diabetes Coling | | | | | | eet, factory, o | iffice | | 28f. Location (City or To | Street and wn, State) | Number or Ru | ural Route Number, | | |
| | To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director; After this certificate his completely filled in by the funeral director, page | Medical C | 29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam | | | | | | | | | | | | |
| | To the H within 24 To the Fo complete | Me | 29b. Signature and title of certifier | | 29c. l | icense numb | ber | | 29d. Date | signed (Mont | h, Day, Year) | | | | |
| | 0/2 | | - Clubos | (iceper | \ | | D39793 Feb. | | | | 1, 200 |)8 | | | |
| 7 | 10 | | 30. Name and address of person who | | | 1 23a) (Type, | Print) | | | | | | | | |
| | | | Christopher J. Ma | ys, M.D | ., 1811 | 1 Prin | nce Ph | 11ip | Drive, | Olney, | MD | 20832 | | | |
| | Sta | | FEB 0 7 2008 33 legistrar's Signature | | | | | | | | | | | | |
| | Registr | ar | ILD UIZU | 100 | ENS. L | " All | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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|---|--------|---|----------|-----|------|---|
| 4 | U | U | 0 | U | U | J |

| | | 1- For State Registrar | | | Certific | cate of | Death | | | F | Reg. No. | | | |
|--|---|--|---|--|--|--|---|---------------------------------------|------------------------------------|---|---|--|--|--|
| Physicia | | Decedent's Name (First, Midd | e,Last) | | | | | 2 | Date of De | | Vee | 3. Tin | ne of Death | |
| Exami | | ROBERT | LE | | יאד כיד | 2 | | | | Month February | 3, 2008 | Year | 08 | 325 hrs |
| | | 4a. Facility Name (if not institution | | | EN, SI | 141 | . City, Town, or | Location of | | | | unty of De | eath | |
| | | 12200 block Nebel St | - | oct and maniporty | | | Rockville | | | | Mor | tgomer | У | |
| | | | | | | | | s. 8. Date of Birth (MM/DD/YYY | | | Birthplace | /State or | | |
| Funeral | | 5. Social Security Number | 6. Sex | 7. Age (| (In yrs. last bi | rthday) | If Under 1 Yea Months Day | | Min, | 8. Date of E | SITTE (MM/DD/ | Fo | reign | |
| Director | | 228-24-1918 | 1X M | 2 F 7 | 77 | Yrs. | World S Day. | 110013 | IVIII. | Oct. | 8,193 | 30 | Country) | irginia |
| | - 1 | Usual Residence of Decedent | | | | | ll | | | | | | | |
| any | ı | 10a. State 10b. County | | 10 | 0c. City, Tow | n or Locatio | ก | | | | | | 10d. | Inside City Limits |
| ě. | | MD Mon | tgom | arv | | Roc | kville | | | | | | 1 | Yes 2 No |
| land f sh | ঠ | | egom | CI y | | 1100 | | | | | 10g. Citizen | of What (| Country? | |
| death with the Maryland or items 23a or 28a-f show must be notified at once. | Director | 10e. Street and Number | | | | | 10f. Zip Code | | | | Tog. Oilizen | OI WINGE | oonay. | |
| the h | ᡖ | 225 N. Van | Bur | en Stre | et | | 208 | 50 | | | J | J.S. | Α. | |
| with s 23 | <u> </u> | 11. Marital Status | | . Was Decedent E | | | Decedent of His | spanic Origi | | | No- 14. | | | idian, Black, |
| ath item | Funeral | 1 Never Married 2 N | larried | Armed Forces? | 7 | If Ye | s, specify Cubar | n, Mexican, | Puerto R | ican, etc.) | | White, et | .C. | |
| r mr | | 3 Widowed 4 Dir | rorced If Ye | | _ No 52-54 | 1 | Yes 2 X No | specify: | | | Sp | ecify: | ${	t Blac}$ | k |
| 5-0036 led within 72 hours after tygiene. other than "natural", | þ | 15. Decedent's Education (Spe | Lor | Dates: | | | 's Usual Occupa | | ind of wo | rk done | 16b. Kind | of Busine | ess/Indust | ry |
| hour natu Exar | Completed | | | | | during mo | st of working life | . DO NOT L | use retire | d) | Mo | nta | omer | у Со |
| 6 1 72 an " | et | Elementary/Secondary (0-12) | | College (1-4 or 5+ | | Risi I d | ing Se | rvice | o Fo | rema | | | | hools |
| Ned | Ē | 12th | | | | | | | | | | | 0 00 | 110015 |
| 5-00 led wit Hygien other | | 17. Father's Name (First, Middle | | | | | | | | | e, Maiden Su | | | 1 |
| 21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sh c event, the Medical Examiner must be notified at once | Be | William Ed | | | Sr | | | Ann: | ie N | <u> Milto</u> | n Gai | ret | <u>t</u> | |
| 그 무용 등 3 | T ₀ | 19a. Informant's Name/Relation | ship (Type, | Print) | | | Address (Stre | | | | | | | |
| MD 21 nd 2 should alth and Me m 27 is ma | | Robert Lee | Alle: | n, Jr (| Son) | 1053 | 4 Sunn | ybro | oke | Lane | , Pot | oma | C.MD | 0854 |
| - P = E E | | 20a. Method of Disposition | | | 20b. Place | e of Disposi | tion (Name of ce | metery, | | Date | 20c. Loc | cation - Ci | ty or Town | , State |
| Baltimore, permit. Pages 1 ar Department of Her Important: If ite | | 1 XBurial 2 Crematic | n 3 X | Removal from State | | atory or oth | | em. | 2/0 | //0 | Eas | + 371 | 110 | 777 |
| Page nent ant: or ot | | 4 Donation 5 Other S | | 7 | | ME Chu | | | | | | | | |
| Baltimo permit. Page Department Important: injury or otl | | 21. Signature of Funeral Service | Licensee | | 22. N | Name and Address of Facility SNOWDEN FUNER | | | | | | HOM | E, P.A. | |
| E E E E | | Thesear T | Ar | rauch | LX | | 46 N. Washington St,1 | | | | | | | |
| hysician | | 23a. Part I. Enter the disease, o | complicat | tions that caused the | he death. Do | not enter th | e mode of dying | , such as ca | ardiac or | respiratory | arrest, shock | , or heart | Ap | proximate Interval etween Onset and |
| 1edical | | failure. List only one caus | _ | _{ine.} tting Wound o | of Mriet | | | | | | | | | Death |
| _xaminer | | Immediate Cause (Final diseas or condition resulting in death) | | to (or as a consec | | | | - | | | | | | |
| | | | _ D06 | to (or as a consec | querioc orj. | | | | | | | | | |
| | | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of): | | | | | | | | | | | | |
| | - | if any loading to immediate | | | | | | | | | | | | |
| | iner | cause. Enter Underlying Cause | | 10 (0) 43 4 00/1300 | | | | | | | | | | |
| | aminer | cause. Enter Underlying Cause (Disease or injury that initiated | c | to (or as a consec | | | | - | | | | | | |
| nted d ansit | Examiner | cause. Enter Underlying Cause | c | | | | | | | | | | | |
| xecuted n and I - transit | cal Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c | to (or as a consec | | | | | | | · | | | |
| be executed sician and ourial - transit | edical Examiner | cause. Enter Underlying Causi (Disease or injury that initiated events resulting in death) Last | c. Due | to (or as a consec | quence of): | | | | | | 1004 | Data of da | Nivery | |
| 760, icate be executed physician and the burial - transit | /Medical Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED IF FEMALE: | c. Due | MENDED 23c. If yes, outcom | quence of): | | and death 3 | Estopis | preonat | 200 | 1 | Date of de | | Year |
| 68760, certificate be executed ding physician and se as the burial - transit | ian/Medical Examiner | cause. Enter Underlying Causi (Disease or injury that initiated events resulting in death) Last | c. Due | MENDED 23c. If yes, outcom | quence of): ne of pregnan | ₂ Fe | | Ectopic | c pregnai | ncy | 1 | Date of de | elivery Day | Year |
| ox 68760, ath certificate be executed attending physician and or use as the burial - transit | sician/Medical | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? | d. A | MENDED 23c. If yes, outcom 1 Live birth 4 Pregnant at t | quence of): ne of pregnan | ₂ Fe | tal death 3 her (Specify) | Ectopio | c pregnar | ncy | 1 | | | Year |
| Box 68760, the death certificate be executed the attending physician and hed for use as the burial - transit | hysician/Medical | cause. Enter Underlying Caust (Disease or injury that initiated events resulting in death) Last UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U | c. Due | MENDED 23c. If yes, outcom Live birth | quence of): ne of pregnan | 2 Fe | her (Specify) | | | | N | l onth | Day | |
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| cords, P.O. Box 68760, Iaw requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - transit | pleted by Physician/Medical | cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Last UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U Part II. Other significant cond | c. Due | MENDED 23c. If yes, outcom Live birth | quence of): ne of pregnan | 2 Fe | her (Specify) | | | 23e. Di 1 24a. W | d tobacco us Yes 2 /as an utopsy erformed? | nonth se contribu No 3 24b. We price | Day ute to the compath? | cause of death? 4 Unknown y findings available letion of cause of |
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| al Records, P.O. Box 68760, an: The law requires that the death certificate be executed ertificate has been signed by the attending physician and stor, page 2 should be detached for use as the burial - transit | pleted by Physician/Medical | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U Part II. Other significant cond | C. Due d. d. A A A A A A A A A A A A A A A A A | MENDED 23c. If yes, outcom Live birth Pregnant at to Unknown Intributing to death | quence of): ne of pregnan | 2 Fe | her (Specify) underlying cause | given in Pa | art I. | 23e. Di 1 | d tobacco us Yes 2 /as an utopsy erformed? es 2 No | se contribu | Day The to the companies or to compath? Yes | cause of death? 4 Unknown y findings available letion of cause of 2 No |
| Vital Records, P.O. Box 68760, ssician: The law requires that the death certificate be executed his certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - transit | Be Completed by Physician/Medical | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U Part II. Other significant cond | C. Due d. d. A A A A A A A A A A A A A A A A A | MENDED 23c. If yes, outcom Live birth | quence of): ne of pregnan time of death | 2 Fe | her (Specify) underlying cause | given in Pa | art I. | 23e. Di 1 | d tobacco us Yes 2 /as an utopsy erformed? es 2 No | se contribu | Day ute to the compath? | cause of death? 4 Unknown y findings available letion of cause of 2 No |
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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amestate of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year **Physician** Month ZAAN/E 0 B846,104 2000 /Medical 4a. Facility Name (It not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner H& VENSI If Under 1 Year Months Days 8. Date of Birth (Month, Day, June 1 6. Sex 7. Age (In yrs. last birthday 9 Birthplace (State or Foreign **Funeral** ^{Year)} 1955 Country) Wash.DC 1 **M** 2 □ F 52 Yrs Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits show 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1XYes 2 No Germantown Director MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20874 U.S.A. 20260 Waters Row Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11 Marital Status Black, White, etc. 1 口Yes 2四~1972**-7**4 If Yes, Give Year or Dates: 1 XNever Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Black þ 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Montgomery Co. Elementary/Secondary (0-12) College (1-4or 5+) ĺ2th Bldg. Service Worker Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cora C. Warren Lawrence R. Adams 19a. Informant's Name/Relationship (Type. Print) (Sister) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20874 Candy C. Adams-Frazier 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Park Crem 2/7/08 Riverdale, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service License 246 N. Washington St, Rockville, MD 20850 23a. Part1. En er the disea e shock, in heart failure. I Immediate Cause (Final disease or condition resulting in death) e, yr complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, LIH only one cause on each line. Approximate Interval Between Onset and Death **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ⊠npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Tes 2 □ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I.

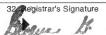
Certification: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year) FEB 07

Shahryar Davari,



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 9901 Medical Center Dr, Rockville, MD 20850

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician Ruth Catherine Ashton rebruary 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Prince Georges Lanham 8. Date of Birth (Month, Day, Ye. Aug. 14, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Year) - 1923 **Funeral** Months D. C. 1 M 2 TyF 577-26-1745 84 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show Examiner must be notified at 1√ Yes 2 No Directo D. C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20003 1519 Independence Avenue, S. E. USA "natural", or items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 陞 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after on tof Health and Mental Hygiene. ont of Health and Mental Hygiene. nt: If item 27 is marked other than "natural", or iter 1 Never Married 2 Married Specify: Black Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Hospital Housekeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Marie Shiver ဥ or other traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Carolyn Harvin 7525 Riverdale Rd., New Carrollton, Md. 20784 (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Glenwood Cemetery 02/11/2008 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee W. H. Bacon Funeral Home, Inc. Jacon (C36) 3447 14th Street, N.W. Washington, D.C. 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Myocardial INFAVCTION **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to or as a consequence of Examine if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖺 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ An Luc wa 1 TYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 3 9 DOA Certification: To 1 Inpatient 2 ER/Outpatient After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 4 hours after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

State

117 SFIT

8118 Good Luck Rd., Lanham, Md.20706

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Jay Zwally, M.D.

Year)

FEB 0 8 2008

| | To the vithing to the total complex co |
|----|--|
| CR | (10) |
| | S Regis |

| | | | Pleas | | | | | delible Ink. artment of H | | | | | ible. | |
|--|-------------------|---|-------------------------------|------------------------|------------|--------------------------------|-------------------------|--|-----------------------------------|---------------------------------------|--------------------------------|---------------------|-------------------------------|---|
| | | For State | | State | JI IVIA | ii yiai iu / | | tificate of l | | a Mentan | Reg. N | 01 | NA | 05309 |
| | - X | Registrar 1. Decedent's Name | e (First, Middle, | Last) | | | | Timodio or I | - Journ | 2. Date o | f Death | | 100 | 3. Time of Death |
| Physicia | | EILE | | , | ADAN | 4S | | | | Month FEBI | RUARY | Day 4 | Year 2008 | 10:50A ^M |
| /Medic Examin | 1000 | 4a. Facility Name (I | | | | | | 4b. City, Town, or | r Location of D | | | | ty of Death | |
| LAGIIIII | 76 | STELLA | MARIS | HOSPICE | | | | TIMONIUM | | | | BA | LTIMO | RE |
| Funeral | | 5. Social Security N | | . Sex | 7. Age | e (In yrs. last | | If Under 1 Year Months Days | If Under 24 I Hours N | Hrs. 8. Date o | f Birth , Day, Yea | ar) | 9. Birth | place (State or Foreign intry) |
| Director | | 578-58-84 | | 1 □ M 2 □ XF | 63 | 3 | Yrs. | | | | 19 19 | | WASH | INGTON, DC |
| and w | | Usual Residence of 10a, State | Decedent 10b. County | | | 10c. City, To | own or Lo | cation | | | | | | 10d. Inside City Limits |
| Aaryla f sho ed at | ٥ | MD | , | GEORGE' | S | 1 | MITCE | HELLVILLE | | | | | | 1 X Yes 2 □ No |
| the N 28a- | Director | 10e. Street and Nu | | | | | | 10f. Zip Code | | | 10g. (| Citizen o | f What Cou | ıntry? |
| filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at | | 2008 UPS | HIRE CO | URT | | | | 20 | 721 | | | USA | | |
| death | Funeral | 11. Marital Status | | 12. Was De Armed F | cedent E | Ever in U.S. | 13. | Was Decedent of H | lispanic Origin an, Mexican, P | ? (Specify Yes o | r No- | | ace - Amer ack, White | ican Indian, , etc. |
| after or ite | | 1 Never Marr | 21 | d 1 ☐ Yes If Yes, G | aive X | No. | | 1 □ Yes 2 □ No | Specify: | | | | ify: BLA | |
| ours ural", | d by | 3 🗆 Widowed | - | Year or | Dates: | 1 | 6a Dece | dent's Usual Occup | ation | | 16h | Kind of | Business/li | ndustry |
| n 72 l "nat edica | lete | | | grade completed | | | (Give | kind of work done DO NOT use retired | durina most of | working | | | | |
| withi iene. • than | Completed | Elementary/Seco | ondary (0-12) 2 +h | College | (1-40r 5 | +) | TELI | E. COMMUU | NICATION | ON | | GOV | ERNME | NT |
| il Hyg other ent, i | BeC | 17. Father's Name | | ast) | | | | | | Name (First, Mi | ddle, Maio | ien Surn | ame) | |
| uld be Aenta rked tic ev | To B | JOHN TY | LER | | | | | | EL | IZABETH | SMI | TH_ | | |
| and hard | 1 | 19a. Informant's N | | | | | | ng Address (Street | | | | | | |
| and and n 27 | | ROGER AD | | BAND | | | | UPSHIRE | COURT | Date | | | | Town, State |
| ges 1 t of H If iten | | 20a. Method of Dis 1 Burial 2 | | 3 □Removal fror | n State | cem | etery, cre | osition (Name of matory or other place | | | | | | |
| t. Pa tmen tant: njury | | | 5 Other (Sp | | | FT. | LINC | OLN CEME 2. Name and Addre | | /12/2008 J. B. | | | | IARYLAND - |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | | 21. Signature of F | 1 / Service L | nara | 1101 | | - 1 | 7474 LAND | | | | | | |
| | | 23a. Part1. Enter | the disease, or o | complications that | t caused | I the death. I | , | ter the mode of dying | | | | | | Approximate Interval Between |
| Physician | | snock, or nea | art tallure. List o (Final | nly one cause on | each III | ie. | | | | | | | 1 | Onset and Death |
| /Medical | | disease or condition resulting in death) | on | | | CANCER a consequen | nce of): | | | | | | | |
| Examiner | | Conventially list of | anditiono | b | | | | | | | | | | |
| P # | iner | Sequentially list co if any, leading to in cause. Enter Und | mmediate erlying | | o (or as | a consequer | nce of): | | | | | | | |
| executed an and rial-transit | Examiner | Cause (Disease or that initiated event resulting in death) | S | c. Due t | o (or as | a consequer | nce of): | | | | | | | |
| be ex ician burial | _ | | | | (0 | | , | | | | | | | |
| rtificate be on physiciants as the buri | adic | | | d | | | | | | | | | | |
| The law requires that the death certificate be ate has been signed by the attending physici page 2 should be detached for use as the bu | Physician/Medical | IF FEMALE: 23b. Was deceder | nt pregnant | | | pf pregnanc | | | | | | | Date of del | |
| death e atte d for | icia | in the past 12 1 ☐ Yes 2 | 2 months? | | gnant at | 2 □ Fetal de t time of deat | | ⊒Ectopic pregnand ⊒ Other <i>(sp</i> ec <i>ify)</i> _ | y | | _ | | Month | Day Year |
| at the de by the a | hys | 9 □ Unknowi | | | | | | | | | Didata | | | the saves of dooth? |
| res that iigned to be deto | by F | Part II. Other sign | ificant condition | ns contributing to | death b | ut not resultii | ng in the u | anderlying cause gi | ven in Part I. | 230. | | | | the cause of death? |
| w requires to been si should b | | | | | | | | | | - ii | | | | |
| e law has b je 2 st | Completed | | · · · | | | | | | | 24a. | Was an autopsy performed | | b. Were au prior to death? | utopsy findings available completion of cause of |
| The cate I | ပ် | | | | | | | | | 10 | Yes 2X | No | 1 ☐ Yes | ≱ ∏ No |
| sician certifi rector | Be | 25. Was case refe examiner? | | Hospital: 4, | | 2005 | 2/0 | oti Oti | hor | Death (Check | | - e V 7 | Other (Cno | cify) HOSPICE |
| Phys r this rral dii | ٦ <u>-</u> | 1 Yes 2 | | 28a. Da | te of Inju | ıry 2 | 8b. Time | of 28c. Inju | | - | cribe how i | | | HUSPICE |
| th. :: Afte | ţi | 1 X Natural 2 ☐ Accident | 5 ☐ Pending investig | , | onth, Da | ly Year) | Injury | | rk?]Yes 2∐No | | | | | |
| Atter | ifica | 3 ☐ Suicide 4 ☐ Homicide | 6 ☐ Could n determi | 200, Pla | ice of inj | jury - At homitc. (Specify) | e, farm, s | treet, factory, office | | | tion (Stree | | mber or Ri | ural Route Number, |
| tal or s afte al Dir ed in | Certification: | Thomaside | | 1 | _ | | | | | | | | | |
| To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page | | 29a. Certifier (Check only | 1X Certifying 2 Medical I | Examiner: On the | e basis c | of examinatio | edge, dea n and/or i | th occurred at the t nvestigation, in my | time, date and opinion, death | place, and due occurred at the | to the caus time, date | e(s) and and pla | manner as ce, and due | s stated. e to the cause(s) |
| thin 2, the f | Medical | one) 29b. Signature and | d title of certifier | and m | anner st | ated. | | 29c. Licen | se number | · · · · · · · · · · · · · · · · · · · | 29d. | Date sig | ned (Mon | th, Day, Year) |
| 5 × 5 8 | _ | 23D. Signature in | | | | | | DY | 372 | | | 21 | 610 | JR |
| | | 30. Name and add | dress of person | who completed ca | ause of o | death (Item 2 | (3a) (Type | | | , | | | | |
| (10) | | DR. TARI | | | | LANEY | | | TMONTI | MD 2 | 093 | | | |
| | ate | 31. Date filed (Mo | onth, Day, Year) | | | | | | | - | | | | |
| Regist | rar | FEB 0 | 8 SAMA | Beau | 70 | 1900 | | | | | | | | |

DHMH 17 Rev 1/2001

| | | | For State Registrar | State | of Marylar | nd / Depa | | t of H | ealth a | | lental Hy | | 008 | 05310 | |
|----------|---|------------------|--|--|--|------------------------------------|----------------------------------|-------------------------|----------------------------|-----------------------|--|-------------------|---|---|--|
| | | | 1. Decedent's Name (First, Middle, | Last) | | | | | | | 2. Date of De. | | Vone | 3. Time of Death | |
| | Physici /Medic | | Elean | or A | indersa | ^ | | | | | Februar | | ₹ Vear | 1500 B W | |
| | Examin | | 4a. Facility Name (If not institution, | give street and n | umber) | | 4b. City, | Town, or | Location o | of Death | | | County of Deatl | h | |
| | | | AUGSBURG LUTHER | | | | | TIMO! | | | | | | | |
| Ų | Funeral Director | | 212-20-7662 | ,Sex 1 □ M 2 💢 F | 7. Age (In yrs | . last birthday) Yrs. | If Under Months | 1 Year Days | If Under: Hours | Min. | 8. Date of Bird (Month, Da JANUARY | y, Year) 29, 1 | 9. Birtl Co NE | hplace (State or Foreign untry) W JERSEY | |
| | and and | | Usual Residence of Decedent 10a. State 10b. County | | 10c. C | ity, Town or Lo | ocation | | | | | | | 10d. Inside City Limits | |
| | Mary F she | Į | FLORIDA LEE | | TO T | RT MYE | RC | | | | | | | 1 ☐ Yes 2 No | |
| | death with the Maryland ms 23s or 28e-f show | Director | 10e. Street and Number | | 10 | TEL XILIS | 10f. Zip | Code | | | | 10g. Citiz | en of What Co | untry? | |
| | 23a o | | 12721 MEADOW PI | NE LANE | | | 3: | 3913 | | | | UNIT | ED STAT | ES | |
| | | Funeral | 11. Marital Status | | cedent Ever in U | J.S. 13. | Was Deced | dent of Hi | ispanic Orig | gin? (Sp | ecify Yes or No Rican, etc.) | - 1 | Race - Ame Black, White | | |
| 30 | hours atter turef, or he | by Fu | 1 ☐ Never Married 2 ☐ Married 3 ∰ Widowed 4 ☐ Divorced | | 2 MNo Give | 1 | 1 🗆 Yes | | Specify: | | | | Specify: WH | | |
| | | ed | 15. Decedent's | Education | | 16a. Dece | dent's Usua | al Occupa | ation | | | 16b. Kin | d of Business/ | Industry | |
| C . | within 72 ene. then 'ns he Mudic | Completed | (Specify only highest Elementary/Secondary (0-12) | grade completed | (1-4or 5+) | (Give | kind of wo DO NOT u | rk done d se retired | during mosi ') | t of work | ing | | | | |
| 717 | d with | E | 12 | Collaga | (1-401 5+) | EXECU | TIVE | SECRI | ETARY | | | MAN | UFACTUR | RING | |
| 2 | be illed tal Hygid d other event, Ill | Bec | 17. Father's Name (First, Middle, La | ist) | | | | | 18. Mothe | er's Nam | e (First, Middle, | Maiden S | Sumame) | | |
| /lan | Ments Ments arked arked | ၉ | CAESAR KRAUSS | | | | | | HAT | TIE | MENKE | | | | |
| Mar | and and is mu | ľ | 19a. Informant's Name/Relationship | (Type, Print) | | | - | | | | al Route Numbe | | | | |
| e) ⊆ | s 1 and f Health Item 27 other tr | | MARK ANDERSON/ S | SON | 201 | | | | LAN | | TEVENSV | | | AND 21666 | |
| _ | Pages 1 nent of H int: If Ite iry or ot | | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 | | n State | Place of Dispo cemetery, crea | matory or o | ther plac | | EBRI | JARY 5 | 20¢, L0¢ | ation - City or | TOWN, State | |
| _ | | | 4 ☐ Donation 5 ☐ Other (Special Signature of Fuñera) Service Lie | | CE | ESAPEA | | | - | | ***** | | | E, MARYLAND | |
| ng Ca | permit. Departr Imports any inje | | 1 Ope C | 10 | 20 | _ 10 | 06 SH | AMRO | CK RO | AD, | CHESTER | , MAI | FUNERA RYLAND | | |
| | | | 23a. Part File the disease, or shock, or hand livre. List or | one cause | caused the dea each line. | ath. Do not en | ter the mod | le of dyin | g, such as | cardiac | or respiratory a | rrest, | | Approximate Interval Between Onset and Death | |
| F | hysician | | Immediate Cause (Final disease or condition a As nivation Incurrons a neutron a neutrons | | | | | | | | | | | | |
| | /Medical Examiner | | resulting in death) | Due t | o (or as a conse | quence of): | | | - (| | | | | 1 | |
| Н | - Adminici | Ļ | Sequentially list conditions, | b. — Dunt | o (or on a conco | guence of): | | | | | | | | | |
| | ed isit | nine | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) | | | | | | | | | | | | |
| | be executed Ician and burial-transit | Examine | that initiated events resulting in death) Last | c Due t | o (or as a conse | quence of): | | | | | | | | | |
| | eath certilicate be executed attending physician and for use as the burial-transit | calE | | d . | | | | | | | | | | | |
| 80 | certificate nding phy use as the | | | 4. | | | | | | | | | | | |
| ROX | anding use a | by Physician/Med | IF FEMALE: 23b. Was decedent pregnant | | outcome of pregressions birth 2 Test | | ⊒Ectopic pi | oanana. | | | | 2: | 3d. Date of del | | |
| | g o g | sicia | in the past 12 months? 1 □ Yes 2 No | | gnant at time of | | Other (sp | | | | | | Month | Day Year | |
| | at the de by the a stached | hys | 9 Unknown | | | | | _ | | | | | | | |
| ś | w requires that the state that the state that the should be detached. | | Part II. Other significant condition | _ | | | ınderlying d Λ' ⊂ ί√ν⊶ | | en in Part I. | • | | | | o the cause of death? | |
| D . | pinoi pinoi | ted | | Hele | orneed | 17/0. | 10(01)- | • • • | | | 10 | Yes 2 | | | |
| ပ္သ | | Completed | | | | | | | | | 24a. Was auto | psy | 24b. Were au | utopsy findings available completion of cause of | |
| _ ' | the cate has page | S | | | | | | | | | 1 ☐ Yes | rmed? 25 No | death? 1 ☐ Yes | 2 □ No | |
| VITAL | Physicien: The law this certificate has braid director, page 2 s | Be | 25. Was case referred to medical examiner? | Hospital: | | | | Othe | _ | | h (Check only o | | | | |
| 5 | this ald | 2 | 1 Yes 2 No 27. Manner of Death | 1 11 | ☐ Inpatient 2 ☐ e of Injury | ☐ ER/Outpaties 28b. Time o | | 28c. Injury | 723110 | ursing Ho | ome 5 Resi | | | cify) | |
| | After fune | tion | 1 To Natural 5 ☐ Pending | (Mo | onth, Day Year) | Injury | м | Worl | k? Yes 2⊟ | No | | , , , | | | |
| DIVISION | l or Attending after death. Director: After in by the fune | fica | 3 Suicide 6 Could no | t be 28e. Pla | ce of Injury - At I | home, farm, st | | | | | | | | ural Route Number, | |
| 5 | alor/ s after il Dire | Certification: | 4 Homicide | bui | lding, etc. (Spec | eify) | | | | ļ | City or To | wn, State) | | | |
| | To the Hospital or At Within 24 hours after of To the Funeral Direct completely filled in by | Medical C | 29a. Certifier 1 Certifying (Check only one) | Physician: To t caminer: On the and ma | he best of my kn basis of examin anner stated. | nowledge, deat nation and/or in | th occurred nvestigation | at the tin | ne, date an pinion, dea | nd place, th occur | and due to the red at the time, | cause(s) a | and manner as place, and due | s stated. e to the cause(s) | |
| | o the | Me | 29b. Signature and title of certifier | 3.19.111 | | | 290 | c. License | e number | | | 29d. Date | signed (Mont | th, Day, Year) | |
| 1 | .Nr | | | 7 | - | $\overline{}$ | | | 03 | 75 | 73 | Feb | VOON! | 4,7008 | |
| | IND | | 30. Name and address of person w | Land | use of death (Ite | | Print) | 7 | eiste | | | ND | 71136 | | |
| | Sta | ite | 31 Date filed (Month Day Year) | | Pagistrar's Sign | Main nature | 21. | K | 18/2] G | V5100 | ~ 1/ | 110 | 0000 | | |
| | Registi | | | 2008 | Prese | & A | Cont | | | | | | | | |

08-01017 Dwight Lerov Bishop

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 05311

| Might Leroy bis | 1- R | For State | | ificate of | | | Reg. | No. | 3. Time of Death | | |
|--|-------------|---|--|-----------------------------------|---------------------------------------|--|--|--|--|--|--|
| Physicia ledical Examir | | Decedent's Name (First, Middle,Last) Dwight | L. Bishop | | | | 2. Date of Death Month Death February 4, 2 | | 1912 hrs | | |
| | 4 | a. Facility Name (if not institution, give Route 301 at Cherry Tree 0 | | 4 | b. City, Town, o Brandywin | r Location of Death e | | 4c. County of Dea Prince Georg | | | |
| Funeral Director | | 6. Social Security Number 6. Sec 212-04-6085 183 | 7. Age (In yrs. la | • | If Under 1 Ye Months Da | | _ | MM/DD/YYYY) 9. E 1970 | Birthplace (State or eign Country) MD | | |
| any | Ŀ | Usual Residence of Decedent 10a. State 10b. County | 10c. City, | Town or Locati | on | | 10d. Inside City Limits | | | | |
| <u>*</u> , | اق | MD Calv | ert | Sund | erland | 1 | 10g | . Citizen of What Co | 1 Yes 2 X No | | |
| th the Mary 23a or 28a notified at | Dire | 10e. Street and Number 6905 Kent Roa | ıd | | | 0689 | | USA | | | |
| WD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-fate marite event, the Medical Examiner must be notified at once | Funeral | 11. Marital Status 1 Never Married 2 Married | 12. Was Decedent Ever in U.S Armed Forces? | | | lispanic Origin? (Sp an, Mexican, Puerto | | White, etc | | | |
| rs after c | <u>a</u> | 3 Widowed 4 X Divorced 15. Decedent's Education (Specify on | or Dates: | 16a Deceden | Yes 2 X N | ation (Give kind of | work done | Specify: B1 | | | |
| 36 in 72 hou than "nati | ompleted | Elementary/Secondary (0-12) | College (1-4 or 5+) | during m | ost of working li | fe. DO NOT use ret Mechani | ired) | Car Dea | lership | | |
| 21215-0036 uld be filed within 72 Mental Hygiene. marked other than 'c event, the Medical | O | 17. Father's Name (First, Middle, Last) Lustine | Bisho | D | | 18.Mother's Name | e (First, Middle, Ma | _ | oks | | |
| Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med | To Be | 19a. Informant's Name/Relationship (T Constance A. Br | vpe, Print) | 19b. Mailin | Address (Str | eet and Number or | Rural Route Numb | | ate, Zip Code) | | |
| ages I and 2 should not of Health and Note: If item 27 is not other traumatic | 911 | 20a. Method of Disposition 1 ABurial 2 Cremation 3 | 20b. I | Place of Dispos | sition (Name of other place) | cemetery, | Date | 20c. Location - City | or Town, State | | |
| Baltimore, permit. Pages 1 at Department of He Important: If ite | | 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licen | Mt | - | | the state of the s | A RESIDENCE OF STREET | | land, MD ome, PA ed.,MD20678 | | |
| M 물질트립 Physician | | Aladiyo Q. S 23a. Part I. Enter the disease, or comp | ewell | | | | | | Approximate Interval Between Onset and | | |
| Medical aminer | à I | failure. List only one cause on ea Immediate Cause (Final disease a. or condition resulting in death) | ach line. Multiple Injuries Due to (or as a consequence of | f): | | | | | Death | | |
| : | - | Sequentially list conditions, if any, leading to immediate | Due to (or as a consequence of | | | | | | | | |
| | Examiner | anusa Enter Underlying Cours | Due to (or as a consequence of | of): | | | | | | | |
| e executed zian and ial - trans | Medical E | d. UNPENDED | AMENDED | <u>.</u> | | | | | | | |
| ox 68760, sath certificate be executed attending physician and for use as the burial - transit | an/Mec | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome of preg | 2 F | etal death | 3 Ectopic pregr | nancy | 23d. Date of del Month | ivery Day Year | | |
| Box 687 e death certific the attending p | Physician/I | 1 Yes 2 No 9 Unknow | 9 Uliknowii | <u> </u> | ther (Specify) | | On- Did to | | te to the cause of death? | | |
| , P.O. | þ | Part II. Other significant conditions | contributing to death but not | resulting in the | underlying caus | se given in Part I. | | | Probably 4 Unknown | | |
| cords, aw require has been si 2 should b | Completed | | | | | | 24a. Was a autops perfor | sy pri o | | | |
| Vital Rec ysician: The la his certificate h director, page. | | 25. Was case referred to medical | | | 26.PI | ace of Death (Chec | 1 Yes 2 | 2 No 1 | Yes 2 No | | |
| Vital hysiciar this cer | o Be | examiner? 1 Yes 2 No | Hospital: 1 Inpatient 2 | ER/Outpatier | | | | Residence 6 🗸 | Other: Scene | | |
| Division of Vital Records, P.O. rater death. al or Attending Physician: The law requires that the start death. al Director: After this certificate has been signed by ted in by the funeral director, page 2 should be detact | tion: T | 27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investiga | 28a. Date of Injury (Month, Day, Year) Feb 4, 2008 | 28b. Time of 1906 hrs | 1 | Injury at Work? Yes 2 ✓ No | Driver auto f | ixed object col | | | |
| O see The second of the second | | | | | | | | | | | |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial. Transi | | 29a. Certifier | cian: To the best of my knowle | dge, death occ and/or investig | urred at the time ation, in my opi | e, date and place, a nion, death occurre | nd due to the caus d at the time, date | e(s) and manner as and place, and due | s stated. to the cause(s) | | |
| To 1 with To 1 | Medical | 29b. Signature and title of certifier | and manner stated. | | 29c. Lic | cense number | | | (Month, Day, Year) | | |
| | i | 30. Name and address of person who | completed cause of death (Ite | m 23a) | | | | 1 0510017 017 | | | |
| u | | Melissa Brassell, MD | Assistant Medical Exam | iner 111 | Penn Stree | t, Baltimore, M | D 21201 | | | | |
| S Regis | tate | SE R. R.3 - 26 / (74.71) | ANGUARI AS | (DOALL | | | | | | | |

| | | 101 | partment of Health and N ertificate of Death | | 711117 | 05312 |
|--|----------------|--|---|---|----------------------------------|---------------------------------|
| | | 1. Decedent's Name (First, Middle, Last) | erillicate of Death | Reg. | No 0 0 0 | 3. Time of Death |
| Physici | | | 1 - | Month | Day Year | M |
| /Medic Examin | | Marilyn 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 7 6, 2008 4c. County of Death | 1:10 a |
| Z LXGIIII | | 15046 Shamrock Ridge Road | Silver Spring | | Montgome | erv |
| Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda | | 8. Date of Birth (Month, Day, Ye | O Diet | nplace (State or Foreign |
| Director | | 482-14-6848 1□M 2X□F 87 Yrs. | World Bays Frodis Will. | April 29, | | owa |
| and | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or | Location | | | 10d. Inside City Limits |
| Maryl f sho | ō | | | | | 1 □Yes 2 □No |
| the 28a- | Director | Maryland Montgomery S: 10e. Street and Number | ilver Spring 10f. Zip Code | 10g. | Citizen of What Co | untry? |
| 3a ol | i D | 15046 Shamrock Ridge Road | 20906 | | USA | |
| ours after death with the Marylan rai" or items 23a or 28a-1 show Examiner must be notified at | Funeral | | Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto | pecify Yes or No- | 14. Race - Amer | |
| or its | Fu. | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 [X] No | 1 ☐ Yes 2 □ No Specify: | o riican, etc.) | Black, White | |
| ural", | d by | 3 🖫 Widowed 4 □ Divorced Year or Dates: | • | | | |
| n 72 "nat | Completed | (Specify only highest grade completed) (Gi | cedent's Usual Occupation ve kind of work done during most of work c. DO NOT use retired) | king | o. Kind of Business/l | industry |
| withi iene. than | E O | Elementary/Secondary (0-12) College (1-4or 5+) | Machine Operator | | Manufact | urina |
| e filed Hyg other | Be | 17. Father's Name (First, Middle, Last) | - | ne (First, Middle, Mai | | ar mg |
| any raind 2 12 13 2000 should be filed within 72 hours after death with the Maryland mind Mental Hygiene. in marked other than "natural" or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at | To B | Edward W. Steffen | Margai | ret Ann Ti | .11 | |
| 2 sho and h is ma | | | illing Address (Street and Number or Ru | | | . , |
| and and m 27 | | | 16 Shamrock Ridge I | | | |
| or of | | 1 Burial 2 □ Cremation 3 ☑ Removal from State | | | c. Location - City or | Town, State |
| it. Pa rtmen rtant: njury | | | of Memories Cemeter | cy W | aterloo, | Iowa |
| permit. Pages 1 and 2 should be filed within 72 hr Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany Injury or other traumatic event, the Medical | | 21. Signature of Funeral Service Licensee | 22. Name and Address of Facility Francis J. Collins 500 University Blvd | Funeral H | ome Inc. | r. MD 20901 |
| 44.00 | | 23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line. | | | | Approximate Interval Between |
| Physician | | Immediate Cause (Final disease or condition | THE INFACTION | | | Onset and Death |
| /Medical Examiner | | | A IMPREDION | | | |
| | <u>.</u> | Sequentially list conditions, Due to or as a cross years. | WSION | | | |
| rted nsit | nin | Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | | |
| be executed sician and burial-transit | Examine | that initiated events resulting in death) Last | | | | |
| cate be executed chysician and the burial-transit | dical | d | | | | |
| | Medi | IS SERVICE. | | | | |
| leath certific attending p | an/I | IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death | 3 □Ectopic pregnancy | | 23d. Date of del | |
| The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as | Physician/Me | in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{DPNo} \) 9 \(\text{Unknown} \) 9 \(\text{Unknown} \) | 5 Other (specify) | | Month | Day Year |
| that the ned by detacl | | Part II. Other significant conditions contributing to death but not resulting in the | e underlying cause given in Part I. | 23e. Did tobac | co use contribute to | the cause of death? |
| signe d be | d by | CONFERTIVE HEART FAILY | UK_ | | | robably 4 Munknown |
| w requir | ete | DAR GOLD | | 24a. Was an | 24h Were at | itopsy findings available |
| The la | Completed | DIABLES MELLINS | | autopsy performe | prior to death? | completion of cause of |
| | | 25. Was case referred to medical | 26. Place of Dea | th (Check only one) | No 1 ☐ Yes | 2 3 No |
| Physici this cer | o Be | examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat | Other: | ome 5 Residence | ce 6 □Other (Spe | cify) |
| ng Ph | n: T | 27. Manner of Death 1 Manner | | 28d. Describe how | injury occurred | |
| tendii eath. or: A | atic | 2 ☐ Accident investigation | M 1 ☐ Yes 2 ☐ No | | | |
| or At fifter d Direct in by | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury · At home, farm, building, etc. (Specify) | street, factory, office | 28f. Location (Stree City or Town, S | et and Number or Ri State) | ural Route Number, |
| spital Surs a leral (| | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, de | eath occurred at the time, date and place | e, and due to the cause | se(s) and manner as | s stated. |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated. | | | | |
| To t To t com | Σ | 29b. Signature and title of certifier | 29c. License number | 29d. | . Date signed (Mont | h, Day, Year) |
| 10 | | · ENALL | 125947 | FE | BRUARY G | 2008 |
| , , | | 30. Name and address of person who completed cause of death (Item 23a) (Type | pe, Print) | ~ | | 105 |
| Sta | ite : | 31. Date filed (Month, Day, Year) 32. Degistrar's Signature | 29c. License number V 25947 De, Print) M ivon Cours, Su | JITE 204 | , DLMy | الموصد والمار |
| Registi | | FEB 0 7 2008 Steen B. A. | parce | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Молth Day 1515 PM 3a 10 2 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 405 rew 9. Birthplace (State or Foreign eck villa If Under 1 Year | If 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Funeral Days Hours Months Min. 1 □ M 2 🖾 F Country) Baku, Republic of Azerbaija Country) Director 213-61-2193 83 July 23, 1924 Usual Residence of Decedent 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director Maryland Rockville 1 ☐ Yes 2 No Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any Injury or other traumatic event, the Medical Examiner must once. 6105 Montrose Road, #3125 20852 Israel Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify. þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Piano Teacher Music 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Yaakov Kopelevich Sima Genina 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tatyana Belenky Feith - Daughter 4835 Cordell Avenue, #406, Bethesda, Maryland 20814 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Har Hamenuchot 02/08/2008 Jerusalem, Israel 21. Signature of Funeral Service Licen 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** preumonio ue to (or as a consequence of): x-Xo-Sequentially list conditions, if any, leading to immediate cause. The Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Partinsonis attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b irector, page 2 s 1756001 performed 25. Was case referred to medical examiner? 2- No Be 26. Place of Death (Check only one) Other: 4♣ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No

/Medical Examiner Hospital or Attending Physician; The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760

the Maryland

with

Baltimore, Maryland 21215-0036

this Certification: After Director: within 24 hours af **To the Funeral D** completely filled in Medical

P

Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 DOA

27. Manner of Death 1. Natural

(Check only

29a. Certifier

5 ☐ Pending investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 4 Homicide

28a. Date of Injury (Month, Day Year) Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

 Location (Street and Number or Rural Route Number, City or Town, State) l 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number D0021884 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

07 2008



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08-01324

Print in Black Indelible Ink. Ensure All Copies Are Legible.

| ıease | Type or Print in Black indelible i | IIIK. | Elisure. | All cobies | SAICL |
|-------|------------------------------------|-------|----------|------------|-------|
| | State of Maryland / Department of | of He | alth and | Mental Hy | giene |

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|-----|-----|-----|-----|-----|-------|-----|-----|-----|
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| 6 | 1.3 | 3.1 | 1.1 | 1.1 | 1.3 | 6.3 | | 9 |

| William Matthew | | achy 1- For State | St | ate of Maryla | and / D | epartm <i>Certific</i> | | | d Mental I | | | 201 | 08 053 | | |
|---|----------------|---|---|------------------------------------|-------------------------|-----------------------------|-----------------------|--------------------------------|----------------------|-------------------------------|---------------------|------------------|-------------------------------|--|--|
| Physicis | | Registrar 1. Decedent's Name | e (First_Middl | e.Last) | | Certific | ale oi | Death | | 2. Date of De | Reg. No. ath | | 3. Time of Death | | |
| Physicia Medical Examir | | William | | | | | | | | Month February | Day 15, 200 | Year 18 | 1602 hrs | | |
| f. in | | | | n, give street and nu | umber) | | 4 | b. City, Town, or | Location of Dea | | 4c. 0 | County of Deat | | | |
| | | 4760 Aldga | te Green | | | | | Baltimore | | | i i | Itimore Co | | | |
| Funeral | | 5. Social Security N | | 6. Sex | | n yrs. last bir | thday) | If Under 1 Year Months Days | | | | Fore | irthplace (State or ign | | |
| Director | | 219 96 3 | 170 | 1 X M 2 F | 34 | | Yrs | | s Hours IV | 07/2 | 4/197 | 3 c | ountry) MD | | |
| | - [| Usual Residence o | | | Lio | c. City, Town | | | | | | | 10d. Inside City Limits | | |
| w any | | 10a. State | 10b. County | imoreo | 10 | Hale | | | | | | | 1 Yes 2 No | | |
| ·land | ģ | MD | _ | imore | | пате | ulor | 10f. Zip Code | | 10g. Citizen of What Country? | | | | | |
| Mary rr 28a | Director | 10e. Street and Nu | | | | | | | | | _ | | | | |
| th the 23a o | | 4760 Ald | gate G | reen 12. Was De | andont Ev | or in II S | 13 Ws | 21227 as Decedent of His | enanic Origin? (| Specify Yes or N | | ted Sta | ates erican Indian, Black, | | |
| rdeath with the Maryland or Items 23a or 28a-f show must be notified at once. | Funeral | Never Marri | ed 2 X M | arried Armed F | orces? | 1 | | es, specify Cubar | | | | White, etc. | | | |
| ter de | | 3 Widowed | 4 Div | orced If Yes, Give Ya | 2 📉 nar | No | 1 | Yes 2 X No | specify: | | S | Specify: V | White | | |
| urs af tural | d by | | | or Dates: cify only highest gra | | eted) 16a. | | nt's Usual Occupa | | | 16b. Ki | nd of Business | s/Industry | | |
| 72 ho | Completed | Elementary/Sec | ondary (0-12) | | (1-4 or 5+) | | | ost of working life | | | ١ | - | | | |
| 5-0036 led within 7 Hygiene. I other than the Medica | ш | | | 4 | | Co | mput | er Analy | | | | | omputers | | |
| 5-0 Iled w Hygio | | 17. Father's Name | | | | | | | | me (First, Middle J. Garl: | | surname) | | | |
| 121 d be fi lental l arked | Be | William 19a. Informant's N | | _ | | 10 | ah Mailin | g Address (Stree | | | | v or Town. Sta | ite. Zip Code) | | |
| D 21 should 1 and Mer 7 is mar | ဥ | | | _ | 30 | 1 | | 2 Globe | | | | | 1.7 | | |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumaite event, the Medical Examiner must be notified at once. | | 20a. Method of Dis | | chy/Fathe | :1_ | 20b. Place | of Dispos | sition (Name of ce | metery, | Date | 20c. L | ocation - City | or Town, State | | |
| OFE ges 1 It of H I: If i | | | | n 3 X Removal | from State | St M | itory or of i chad | her place) e.] "s Cem | etery 2 | -21-200 | 8 We | st Sal: | isbury, PA | | |
| Baltimore, permit. Pages I an Department of Hea Important: If ite | | 4 Donation 5 | Other S | | | 401044 | | | -1 | | | | mily FH Inc. | | |
| Depart Imp |) (| Make 6 | Mrs | allely | | | 4 | 112 old | Columbi | a Pike 1 | Ellic | ott Cit | | | |
| Physician | | 23a. Part I. Enter t | a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and | | | | | | | | | | | | |
| Medical vaminer | | Immediate Cause | • | Fontant | 1 into | oxicatio | on | | | | | | Death | | |
| * Caminei | | or condition result | | | a consequ | uence of): | | | | | | | | | |
| | F | | condition resulting in death) Due to (or as a consequence of): b. Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | | |
| | nine | cause. Enter Und (Disease or injury | erlying Cause | 6. | | | | | | | | -5 8- | 4 | | |
| sd saft | Examine | events resulting in | | Due to (or as | a conseq | uence of): | | | | | | | | | |
| 0, be executed sician and burial - transit | dical | THE LINDSHIDE | <u> </u> | d | 17.00 | <u> </u> | <u>т</u> | 76 0 /00 /00 |) mm' | | | | | | |
| o, e be e ysicia burial | | X UNPENDE | | | | of pregnanc | | 76, 2/28/08 | 5 11 | | 230 | d. Date of deliv | very | | |
| 876 tificat ng ph as the | N/N | IF FEMALE: 23b. Was deceden past 12 month | | ib o | birth | or programo | | etal death 3 | Ectopic pre | gnancy | | Month | Day Year | | |
| Box 68760 e death certificate I the attending physied for use as the b | sician/M | 1 Yes 2 | | diameter 1 | | ne of death | 5 C | ther (Specify) | | | 8 | | 1 | | |
| BC BC He deg | Phys | | | itions contributing | nown | out not resulti | ing in the | underlying cause | given in Part I. | 23e. Di | d tobacco | use contribute | to the cause of death? | | |
| Division of Vital Records, P.O. rat or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach | by | Part II. Other sign | inicant cond | done contributing | to death. | 30(110(1000)) | | 22,g | 3 | 1 | Yes 2 | No 3 F | Probably 4 🗸 Unknown | | |
| ds, land | ted | | | | | | | | | 24a. W | | | autopsy findings available | | |
| Corc law re has be 2 sho | nple | | | | | | | | | — pe | itopsy erformed? | death | | | |
| Re(The ficate | Completed | | | | | | | 26 Plac | ce of Death (Ch | 1 Ye | s 2 N | 0 1 🗸 | Yes 2 No | | |
| ician: s certi | Be | 25. Was case refe examiner? | - | Al Hospital: | Inpatien | 2 FR/ | Outpatier | | Othor: | ursing Home 5 | Reside | ence 6 🗸 O | ther: Scene | | |
| of V Phys eral di | 5 | 1 Yes 27. Manner of De | 2 No | 28a. Da | te of Injury | / 28 | . Time of | | jury at Work? | | be how inju | ury occurred | | | |
| nding ra Af | ion | 1 Natural | | | nth, Day,Yea 2/15/ | | nd 3;4 | 45 pm 1 1 | Yes 2 X No | unk | | | | | |
| risic r Atte er dea recto | ficat | 2 Accident 3 Suicide | ₩- | | | | | eet, factory, office | building, etc. | | | | Rural Route Number, City | | |
| Div urs aft | Certification: | 3 Suicide 4 Homicide | | ermined (Specif | y) fou | nd at h | ome | | | 4760'A | Idgate | Green B | altimore, MD | | |
| Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b | | 29a. Certifier 1 | Certifying | Physician: To the b | est of my | knowledge, c | leath occ | urred at the time, | date and place, | and due to the | cause(s) ar | nd manner as | stated. | | |
| Fo the Vithin To the | Medical | one) 2 | _ | aminer:On the bas and manne | is of exam r stated. | ination and/o | rinvestig | | | ed at the time, c | | | | | |
| | Ž | 29b. Signature an | d title of certif | ier | ^ | | | 1 | nse number C.M.E. | | - 1 | oruary 16, 2 | (Month, Day, Year) 2008 | | |
| | | Tate | U | - Kall | le | MO | | | 7.1VI.L. | | | | | | |
| (5)02 | | 30. Name and add | | on who completed ca ak MD. Assi | | ath (Item 23a edical Exa | | 111 Penn \$ | Street, Baltir | nore, MD 21 | 201 | | | | |
| 9 | tate | | |) 32. | | s Signature | | A | | | | | | | |
| Regis | | | ttB 1 | 9 2008 | Block | as St | A | mark) | | | | | | | |
| DHMH 17 Rev 1/2 | 2001 | | | | | c | RIGIN | AL | | | | | | | |

| | | | For | State of Maryland / | - | rtment of Health and N | lental Hy | giene | 2000 | 00010 | | |
|------------|---|-------------------------|---|---|--------------------------|--|--|--|---|---|--|--|
| | | | 1 - State Registrar | | Cert | tificate of Death | T | Reg. No. | 2008 | 00010 | | |
| | Physicia | an | 1. Decedent's Name (First, Middle, Last) $BEULAH \qquad \qquad L$ | . BURTON | | | 2. Date of De Month | Day | Year | 3. Time of Death 3:10 pm | | |
| | /Medic Examin | | 4a. Facility Name (If not institution, give s | | | 4b. City, Town, or Location of Death | 02_ | 06 4c. 0 | 2008 County of Death | J. T. J. | | |
| | Examin | ei | | | | | | | ince Ge | orge | | |
| - 4 | Funeral | | Southern Mary 1 5. Social Security Number 6. Sex | | birthday) | Clinton If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Bit | th av Vear) | 9. Birthpi Coun | ace (State or Foreign | | |
| | Director | | 577 26 7621 Usual Residence of Decedent | M 212 F 9.7 | Yrs. | Working Days Flours Will. | 8. Date of Bir (Month, Da 8 / 21 | /191 | 0 Miss | issippi | | |
| | and w | | 10a. State 10b. County | 10c. City, To | own or Loc | ation | | | 11 | 0d. Inside City Limits | | |
| | Maryl f sho | to | D.C. | Wash | ingt | on | | | | 1 □Yes 2 No | | |
| | r 28a | irec | 10e. Street and Number | | | 10f. Zip Code | | 10g. Citize | en of What Coun | try? | | |
| | th with | al D | 5000 Nannie He | elen Burrough | Ave | 20019 | | | U.S.A. | | | |
| | be filed within 72 hours after death with the Maryland ital Hygiene. A other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Funeral Director | | 12. Was Decedent Ever in U.S. Armed Forces? | | /as Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto | ecify Yes or No Rican, etc.) | | 4. Race - America Black, White, | | | |
| 30 | s afte | by Fi | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | | ☐ Yes 2☐ No Specify: | | Ì | Specify: Bla | | | |
| 2-003 | tural tural | ed b | 15. Decedent's Educ | | 6a. Decede | ent's Usual Occupation | | | d of Business/Inc | | | |
| 2 | in "na In "na Medic | Completed | (Specify only highest grade Elementary/Secondary (0-12) | | (Give k life. D | ind of work done during most of work O NOT use retired) | ting | | | , | | |
| 7 | d within giene. | ĕ | 12+h | College (1-401 5+) | Bea | utician | | Pri | vate | | | |
| 9 | be file Ital Hy Id othe event | Be (| 17. Father's Name (First, Middle, Last) | | | 18. Mother's Name | | (First, Middle, Maiden Surname) Fields | | | | |
| yıa | should by marked maric ev | 2 | Ben Lacey | | _ | | | | | | | |
| Mar | 12 sh h and 7 is m rraum | | 19a. Informant's Name/Relationship (Type | ne. Print) | 9b. Mailing 8315 | Address (Street and Number or Run Seville Stree | ral Route Numb C | er, City or | Town, State, Zip | Code) | | |
| e) | 1 and Health em 27 | | Betty Thompso 20a. Method of Disposition | n, cousin | Univ | | t Lou: | | $\frac{\text{Mo}}{\text{ation}} = 6313$ | | | |
| DE L | permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marke any injury or other traumatic once. | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) | emoval from State Fort | tery, crem Line | atory or other place) coln Cem 2/1 | 5/08 | | twood, | | | |
| апшо | Department Important: Important: I any Injury conce. | | 21. Signature of Funeral Service License | ee | | Name and Address of Facility HA | I.I. BRC | THER | S FUNE | RAL HOME | | |
| ă | permi Depar Impor any ir | | I for love | MD#1161 | | 1 Florida Aven | | | | | | |
| | Physician /Medical Examiner | _ | 23a. Tart1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | |
| ,00,0 | cate be executed physician and the bunal-transit | dical Examiner | Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consequence | 20 | resnation matra | <u> </u> | | a | in line so | | |
| Ó | certificate ding physise as the | Med | IF FEMALE: | | | | | I | | | | |
| O. DOX | w requires that the death certific been signed by the attending I should be detached for use as | Physician/Me | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown | 3c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown | ath 3 🔲 | Ectopic pregnancy Other (specify) | | 23 | 3d. Date of delive Month | ry Day Year | | |
| בי, ב | quires tha | þ | Part II. Other significant conditions con | tributing to death but not resulting | g in the und | derlying cause given in Part I. | | | se contribute to th] No 3 ☐ Prob | e cause of death? | | |
| II Records | The la ate has page 2 | Completed | | | | | 24a. Was auto perfo 1∐ Yes | | death? | osy findings available npletion of cause of | | |
| | iclan certifi ector, | Be | 25. Was case referred to medical examiner? | lospital: | | 26. Place of Deat | | | | | | |
| 5 | 0 + 0 | ٦. | 1 Yes 2 No | 1 Inpatient 2 ER/C | Outpatient b. Time of | | ome 5 Res | | Other (Specify |) | | |
| 5 | ding h. After funer | tion | 1 ■ Natural 5 □ Pending | (Month, Day Year) | Injury | 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No | 260. Describe | now injury | occurred | | | |
| DIVISION | i or Atten after deat Director | Certification: | 2 Accident investigation M 1 Yes 2 No 3 Suicide 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route City or Town, State) | | | | | | | I Route Number, | | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | Medical C | 29a. Certifier 1 Certifying Phys (Check only one) | iclan: To the best of my knowled per: On the basis of examination and manner stated. | dge, death and/or inv | occurred at the time, date and place, estigation, in my opinion, death occur | and due to the | cause(s) a , date and | and manner as st place, and due to | ated. the cause(s) | | |
| | Vith To t | Ź | 29b. Signature and title of certifier | | | 29c. License number | | | signed (Month, | | | |
| , | | | · MATA | Mest | | 50934 | | Feb | un-y) | 6,08 | | |
| 12 | (2) | | 30. Name and address of person who to | npleted cause of death (Item 23a | a) (Type, F | 3-350 For | twash | y Tu | OMDZ | 0744 | | |
| | Sta Registr | _ | FEB 1 1 2008 | 32. Registrar's Signature | de | | | | | | | |

State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend Certificate of Death 19a, perFH, G877 3/6/08 TT 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2:50 P M February 4, Dorothy T. Beach 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Keswick Nursing Facility Baltimore 8. Date of Birth (Month, Day, Year, Dec. 19, 1 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🛱 F 1913 Maryland 214-12-0290 94 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. wither than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21217 301 McMechen Street #513 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 is marked other than "natural", or items traumatic event, the Medical Examiner ma Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □ Y*e*s 2 📉 No Specify. Specify: Completed by 3 XWidowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher's Aide DC Public Schools 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fill and Mental H Frances Williams Rufus Thompson ၀ 19a. Informant's Name/Relationship (Type. Print). 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 is ury or other tra 301 McMechen Street #513 Baltimore, MD Imogene S. Sanders/Daug 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐Removal from State Department o Important: If any injury or Harmony Memorial Park 02-11-2008 | Landover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4217 9th Street, NW Washington, DC 20011 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
USELS Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 I Inknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autonsy page perform rmed? 2 No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA ို 1 🗌 Yes 1 | Inpatient this After the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No · death. 2 Accident d in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hin 24 hours after the Funeral Dire mpletely filled in b hours after Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 6701 N. Charles St. Balto, MO 21707 ress of person who completed cause of Jeath (Item 23a) (Type, Print) 30. Name an ad 32. Registrar's Signat State Registrar

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) 8 2008 FEB 0

30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner Ana Rubio MD. 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month By, Year) 2008

and manner stated

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

29a. Certifier 1

29b. Signature and title of certifier

Medical

State

Registrar

29d. Date signed (Month, Day, Year)

February 1, 2008

| | | | 1 - For State Registrar | State of M | Marylan | | artment <i>rtificate</i> | | | Mental Hy | ygiené Reg. No | -00 | 8 | 05319 |
|----------------------------|--|-----------------|--|--|---------------|---------------------------------|-----------------------------|--|-------------------------------------|---------------------------------|-------------------------|--------------------|------------------------------|--|
| | | | Decedent's Name (First, Middle, Last) 2. Date of Death | | | | | | | | 3. Time of Death | | | |
| | Physici /Medio | | HELEN LEE BRODEN | | | | | | | FEBRUA | RY 3 | | 800 | 9:30 A _M |
| | Examir | er | 4a. Facility Name (If not institution, give | street and numbe | r) | | 4b. City, T | own, or Lo | cation of Death | | 4c. | County of | Death | |
| | | | 515 QUEENS DRIVE | | 4 | Carlottate de N | | NSTO | N Under 24 Hrs. | | | JEEN . | | |
| | Funeral Director | | 5. Social Security Number 6. So | ox □M 2 ∑ F /. A | | last birthday) Yrs. | | | Hours Min. | 8. Date of B | Day, Year) | 10 | | place (State or Foreign |
| | | | 216-46-4591 Usual Residence of Decedent | | 95 | | | | | JULY 2 | 8, 19 | 12 1 | NEW | JERSEY |
| | yland | | 10a. State 10b. County | | 10c. City | , Town or Lo | cation | | | | | | 1 | 0d. Inside City Limits |
| | e Mar | ctor | MARYLAND QUEEN AN | INE'S | QI | JEENSTO | OWN | | | | | | | 1 ☐ Yes 2 No |
| | or 28 | Director | 10e. Street and Number | | | | 10f. Zip C | ode | | | 10g. Cit | izen of Wh | at Cour | ntry? |
| | 23a | ra | 515 QUEENS DRIVE | | | | 216 | 58 | | | UNI | CED S | TATI | ES |
| | er de | Funeral | 11. Marital Status | 12. Was Deceden | 5? | | Vas Decede 1 Yes, specif | nt of Hispa y Cuban, I | anic Origin? (S) Mexican, Puerto | pecify Yes or N Rican, etc.) | lo- | | Americ White, | ean Indian, etc. |
| 36 | rs att | by F | 1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates | 7 | , | I□Yes 2 | No S | Specify: | | | Specify: | WHIT | Œ |
| Maryland 21215-0036 | be filed within 72 hours atter death with the Maryland Ital Hygiene. Id other than "natural", or Items 23s or 28s-f ehow event, the Medical Examiner must be mutified at | | 15. Decedent's Ed | | | 16a. Deced | ient's Usual | Occupatio | n | | 16b. K | ind of Busi | ness/In | dustry |
| 715 | n n | Completed | (Specify only highest grade Elementary/Secondary (0-12) | de completed) | (F.) | (Give | kind of work OO NOT use | done duri | ng most of won | king | | ST GR | | |
| 5 | d with | E O | Elementary/Secondary (0-12) | College (1-4o | 1 3+) | TEACHI | ER | | | | | CATIO | | |
| b | be filed ita! Hygi id other event, I | Bec | 17. Father's Name (First, Middle, Last) | | | | | 18 | . Mother's Nam | e (First, Middle | e, Maiden | Sumame, | | |
| <u>ya</u> | should be nd Mental marked umatic ev | 7 | THOMAS BENJAMIN LE | EE, M.D. | | | | ŀ | HELEN W. | ILLETS | | | | |
| lar | and and is mu | 60 Tu | 19a. Informant's Name/Relationship (7 | ype, Print) | | 19b. Mailin | g Address (| Street and | Number or Ru | ral Route Numi | ber, City o | r Town, S | tate, Zip | Code) |
| <u>≥</u> | and lealth m 27 her tr | | HELEN TRUMPY HOMPH | E/DAUGHTE | | | | | E, QUE | | - | | | |
| Baltimore, | ges 1 t of H if ite or ot | | 20a. Method of Disposition 1 ☐ Burial 2 Macremation 3 ☐ | Removal from Stat | | tace of Dispo- emetery, cren | | | FEBR | Date UARY 5 | 20c. Lo | ocation - C | ity or To | own, State |
| Ë | t. Pa tmen tant: | | 4 ☐ Donation 5 ☐ Other (Specify |) | | SAPEAK | | | | 800 | | ENSV | LLE | , MARYLAND |
| Bal | permit. Pages 1 and 2 should by Depertment of Health and Menta Important: If Item 27 ie marked any injury or other traumatic enone. | Į. | 21. Signature of Funeral Service Licen. | 500 | M006 | 72 CR | . Name and EMATI(| Address o | Facility FF | LLOWS AL CARI | HELFI | ENBEI A. | N, N | VEWNAM |
| | | | | dications that cause | | 81 | 4 BEST | GATE | ROAD, | <u>ANNAPOI</u> | IS, | MARYI | AND | 21401 Approximate |
| | Physician /Medical | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Immediate Cause (Final | | | | | | | | | | Interval Between | |
| | | | disease or condition CEREBROVASCULAR INSUFFICIENCY | | | | | | | | | | | |
| | Examiner | | Due to (or as a consequence of): Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or as a consequence of): Luc to (or as a consequence of): | | | | | | | | | | | |
| | ję. | ē | | | | | | | | | - | | | |
| | sicien and burial-transit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | | | | |
| ó | exec en an rial-tr | Exa | resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | | |
| 8760, | icate be executed physicien and s the burial-transit | dlcal | | d | | | | | | | | | | |
| မှ | ing ph | Med | IF FEMALE: | | | | | | | | | | i | |
| Вох | eath certifi attending for use as | lan/ | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcom 1□Live birth | 2 Fetal | death 3 [| Ectopic preg | | | | | 23d. Date Montl | | ery Day Year |
| o O | the a | /s c | 1 ☐ Yes 2 MNo 9 ☐ Unknown | 4□Pregnant: 9□ Unknown | at time of de | eath 5 | Other (spec | :ify) | | | | WORK | | Day real |
| Δ. | The law requires that the death certific site has been signed by the attending page 2 should be detached for use as | by Physician/Me | Part II. Other significant conditions co | antichuting to death | but not resu | ulting in the un | derhijne car | co awan i | n Dad I | 23a Did | tobaccou | ica contrib | ute to th | ne cause of death? |
| ds, | uires t signe id be c | ξ | HTN | and the control of the control | Dat Hot 1630 | inting in the di | idenying cau | se given i | iraiti. | | Yes 2 | | | ably 4 Unknown |
| Ö | w requ | etec | | | | | | | | - | | | | - |
| Rec | has be 2 : | Completed | DEMENTIA OF THE | ALZHEIME | R'S TY | PE | | | | | s an opsy formed? | 24b. We | ere auto or to co ath? | psy findings available mpletion of cause of |
| Division of Vital Records, | hysician: The law his certificete has t il director, page 2 s | င္ပ | 25. Was case referred to medical | | | | | | | 1 ☐ Yes | 2 X № | | Yes | 2 ⊠ No |
| 5 | Physician: rthis certifice ral director, p | m | examiner? | Hospital: 1 ☐ Inpat | iont 2 🗆 I | ER/Outpatient | t 3 DOA | Other | 6. Place of Dea | | | | <i>'</i> 0 <i>'</i> | |
| ō | 9 Phys er this eral di | n: To | 27. Manner of Death | 28a. Date of In | iurv | 28b. Time of | | 18c. Injury at 28d. Describe how injury occurred | | | | | <u>//</u> | |
| <u>o</u> | Attending r death. ector: After by the fune | ate | 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation | (Month, D | ay rear) | Injury | м | Work? 1 ☐ Yes | 2 🗆 No | | | | | |
| <u> </u> | Atten er dea rector by the | 을 | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined | 28e. Place of Ir | njury - At ho | me, farm, stre | eet, factory, | office | | 28f. Location | (Street an | d Number | or Rura | I Route Number, |
| ā | To the Hospital or Attending Ph within 24 hours elter death. To the Funeral Director: After th completely filled in by the funeral | Certification: | | Odilding, 6 | | , | | | | Only of 10 | , Olaib | , | | |
| | Hospital 24 hours E Funeral I tely filled | edical | 29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam | rsician: To the bes | t of my know | wledge, death | occurred at | the time, | date and place, | and due to the | e cause(s) | and mann | er as si | tated. |
| | To the P within 24 To the F complete | Medi | one) | and manner s | stated. | | | | | | | | | |
| | S S S | = | 29b. Signature and title of certifier | (han. | FI | 71 | | License nu | | | ∠90. Dat | e signed (| wonth, | Day, Year) |
| | ļ | D35048 | | | | | | | | FEBR | UARY | 4, | 2008 | |
| 1, | 125 | | 30. Name and address of person who c | | | | • | 1 D | | | | | | |
| 4 | Sta | to. | ERIC F. CIGANEK, 31. Date filed (Month, Day, Year) | 32. Redis | trar's Signat | ure | | | ENTREVI | LLE, M | ARYL.A | ND 2 | 1617 | |
| | Registr | | FEB 0 6 | 2008 | · Suc | N. A | book | , | | | | | | |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Month Year **Physician** Margaret Gertrude February 10, 2008 10:30 pm /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 20808 Hermanville Road Lexington Park St. Mary's 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Hours 1 M 2 XF Director 579-70-9179 62 Maryland 08/10/1945 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County notified at 1 Yes 2 No Director Maryland St. Mary's Lexington Park 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or any Injury or other traumatic event, the Medical Examiner must be I 20808 Hermanville Road Funeral 20653 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Food Service Manager State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Edward Lee Herbert <u>Gertrude Virginia Beander</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie D. Herbert/Daughter 20808 Hermanville Road, Lexington Park, MD 20653 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) First Missionary Cem | 02/15/2008 Lexington Park, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Road, Leonardtown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a presequence of): **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed Due to (or as a consequence of) physician are the burial-t P.O. Box 68760 Physician/Medical IF FEMALE: asn 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 2 | Fetal death 1 ☐ Live birth in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 4☐Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No I or Attend after death. Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral C 29a. Certifier 1 🖰 CertifyIng Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 40055751 2-12-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Schmidt, Jennifer -D.O. 40900 Merchants Lane, Leonardtown, MD 32. Registrar's Signatur 31. Date filed (Month, Day, Year) FEB 1 3 2008 M Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| Deposite the term Plant Assistance Deposite the term Plant Assistance St. Mary 18 May 12 May 200 St. Mary 18 May 2 | | | | 1- State of Maryland / Registrar | Department of H Certificate of L | | | iene g. No. | 05321 | | | | |
|--|----------|---|--------------|--|---|--|---|--|-----------------------------------|--|--|--|--|
| St. Mary is Nursing Center and manhol. St. Mary is Nursing Center by Mary Land in Nursing Ce | | | | Mary Magdalene Cullison February 10 2008 | | | | | | | | | |
| Provided The property The prop | | | الأأكماء بحد | | 4b. City, Town, or | Location of Death | | 1 | | | | | |
| Director Director | | | | · · · · · · · · · · · · · · · · · · · | | | | | | | | | |
| 166 State 167 Courty 168 Page 168 State 168 | | | | 213-40-7869 1 M 2XXF 91 | Months Days | | 8. Date of Birth (Month, Day, January 1 | 9. E 8,1917 Ma | Country) | | | | |
| James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter James Anne (Floatingship) James Walter James | | and and | | | wn or Location | | | | 10d. Inside City Limits | | | | |
| James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter James Anne (Floatingship) James Walter James | | Maryl f sho | 호 | Maryland St Mary's Va | llev Lee | | | | | | | | |
| Second | | r 28a | irec | | | | 11 | 0g. Citizen of What | Country? | | | | |
| James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter James Anne (Floatingship) James Walter James | | h with | at D | 45154 Andover Estates Road | 206 | 92 | | USA | | | | | |
| James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter James Anne (Floatingship) James Walter James | | deat | ner | | 13. Was Decedent of Hi | ispanic Origin? (Sp | ecify Yes or No- | | | | | | |
| James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter James Anne (Floatingship) James Walter James | 920 | urs after al", or ite | þ | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No | | | nicari, etc.) | Consider | | | | | |
| Second | 20 | 72 ho natur fical | eted | 15. Decedent's Education 16 (Specify only highest grade completed) | a. Decedent's Usual Occup: | ation during most of work | ina | 16b. Kind of Busines | ss/Industry | | | | |
| James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter Wood James Walter James Anne (Floatingship) James Walter James | 7 | ithin ne. | mple | Elementary/Secondary (0-12) College (1-4or 5+) | | d) | ing . | 0 1 | T | | | | |
| Second | 5 | iled w Hygie ther t | ပ္ပ | | потетакет | 18 Mother's Name | First Middle A | | iome | | | | |
| Physician Medical Examiner Physician Medical Examiner Physician Medic | ano | d be f ental l ced or |) Be | | | | | , | | | | | |
| Physician Medical Examiner Physician Medical Examiner Physician Medic | ₹ | shoul nd Me mark | ř | | Db. Mailing Address (Street a | | | | , Zip Code) | | | | |
| Physician Medical Examiner Physician Medical Examiner Physician Medic | ž | alth a 27 is | | | | | | | | | | | |
| Physician Medical Examiner Physician Medical Examiner Physician Medic | e, | of He | | 20a. Method of Disposition 20b. Place | of Disposition (Name of | 1 - 1 - | | | | | | | |
| Physician Medical Examiner Physician Medical Examiner Physician Medic | <u>E</u> | Page ment o | | INTEGRAL 2 Cremation 3 Hemoval from State | | | 2008 | Great Mills, | Maryland | | | | |
| Pityslician (Medical Examilinor Potyslician (Medical Examilinor Potyslician (Medical Examilinor) Potyslician (Medi | Balt | permit. Departr Importa any inju | | | | | | | | | | | |
| Population // Medical Examiners Population // Medical Examiners Popul | 1 | Sink | | 23a. Part1 Enter the disease, or complications that caused the death. Do | | 100 | | | Approximate | | | | |
| Due to (or as it confidence on the confidence of | ä | Physician | | Immediate Cause (Final | | | | | | | | | |
| Sequentially list conditions as a consequence of the part of the past 12 months? Sequentially list conditions are sequenced and the past 12 months? 23d. Date of delivery months are sequenced of the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months are sequenced on the past 12 months? 23d. Date of delivery months are sequenced on the past 12 months are sequenced on the past 12 months are sequenced on the past 12 months are sequenced on the past 12 months are sequenced on the past 12 months are sequenced on the past 12 months are sequenced on the past 12 months are sequenced on the past 12 months are sequenced on the past 12 months are sequenced on the past 12 months are sequenced on the past 12 months are | | | | resulting in death) | e of); | 1 | 2 | | 341 | | | | |
| Section Part | | Examiner | | Sequentially list conditions. | votic | -ticida | Otel | | Jacks | | | | |
| FFEMALE: 25. Was decedent pregnant 1 1 1 1 1 1 1 1 1 | | sit 9d | ine | cause. Enter Underlying | 101 / En | 0 - | (27) | | 1.0.0 | | | | |
| FFEMALE: 25. Was decedent pregnant 1 1 1 1 1 1 1 1 1 | _ | and I-tran | хап | that initiated events | KW 13 | | | mes | | | | | |
| FEMALE: FEMALE: | 9 | be e | E E | Too | minal | Crah | solia | | 10/31 | | | | |
| FEMALE: FEMALE: | 687 | ficate p phys | edic | d | ZY MINNE | Circle 1 | year | | 1 7 | | | | |
| DOOD Not be the complete of th | XO | n certi | No. | 23b. Was decedent pregnant 23c. If yes, outcome pt pregnancy | | | | 23d. Date of o | delivery | | | | |
| DOOD Not be the complete of th | O. B | he death the atte | ysicla | 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death | | | | Month | Day Year | | | | |
| DOOD Not be the complete of th | σ. | that t ed by detac | | | in the underlying cause give | en in Part I. | 23e. Did tob | acco use contribute | to the cause of death? | | | | |
| 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 | ords | equires sen sign ould be | | | | | 1 □ Ye | es 2 ∏ No 3□ | Probably 4 Unknown | | | | |
| 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 27. Manner of Death 1 | Rec | he law r s has be ge 2 sh | mple | | | | autops | y prior t | o completion of cause of | | | | |
| Adding the property of the pro | ta | | | 25. Was case referred to medical | | 26 Place of Deet | 1□ Yes 2 | 2 No 1 □Y | es 2 No | | | | |
| The state of the s | | ysicia is ceri | 00 1 | examiner? | Outpatient 3 DOA Othe | or . | | | necify) | | | | |
| The state of the s | <u></u> | ng Ph ter thi | | A CALL CONTRACTOR | . Time of 28c. Injun | | | | , cony, | | | | |
| The state of the s | Ö | endir ath. or: Af he fur | atio | 2 Accident investigation | | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23t) (Type, Print) James P. Jarboe, M.D. 24035 Three Notch Road Hollywood, MD 20636 State 31. Date filed (Month, Day, Year) 32 Polistrar's Signature | | l or Att after de Directe | ertific | determined 20e. Flace of Injury - At notife, | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23t) (Type, Print) James P. Jarboe, M.D. 24035 Three Notch Road Hollywood, MD 20636 State 31. Date filed (Month, Day, Year) 32 Polistrar's Signature | | Hospita 24 hours Funeral tely filled | | (Check only 2 Medical Examiner: On the basis of examination a | ge, death occurred at the tin and/or investigation, in my o | ne, date and place, pinion, death occur | and due to the ca | ause(s) and manner ate and place, and c | as stated. lue to the cause(s) | | | | |
| 30. Name and address of person who completed cause of death (Item 23t) (Type, Print) James P. Jarboe, M.D. 24035 Three Notch Road Hollywood, MD 20636 State 31. Date filed (Month, Day, Year) 32 Polistrar's Signature | | ro the orthe omple | Med | and marine stated. | 29c. License | e number , | O 25 | 9d. Date signed (Mo | nth, Day, Year) | | | | |
| James P. Jartoe, M.D. 24035 Three Notch Road Hollywood, MD 20636 State 31. Date filed (Month, Day, Bar) 32. Figure 1. 20036 | | | | I lamsit bullers | M) D | 0641 | 7 | 2-11-0 | 8 | | | | |
| State 31. Date filed (Month, Day, year) 32. Polistrar's Signature | • | 100 | ŀ | 30. Name and address of person who completed cause of death (Item 23) |) (Type, Print) | 01, | 1 | | | | | | |
| one one of the one of | | 170 | | | ee Notch Road | l Holly | wood, MD | 20636 | | | | | |
| | | | 2 | 31. Date filed (Month, Day, Mear) FFR 1 3 2008 | And I | | | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Amend Item 24a per verb., g877 93/07/08dhbeath 05322 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear Month **Physician** <u>7:</u>30 ₽ ^M Pearl Elizabeth Ciampo February 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Memorial Hospital Calvert Prince Frederick Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🖔 F 85 577-20-9214 Director Jan. 26 1923 Washington DC Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Charles Hughesville 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 20637 United States 16805 Teagues Point Road Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ZNNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married "natural", or i 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 XWidowed 4 ☐ Divorced white Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other treasment. retail sales cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Harry Perry Leigh Curtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16805 Teagues Point Rd. Hughesville, MD Earl Lewis Perry, Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4□Donation 5X1Other (Specifyentombment Southern Mem. Grdns | 02-08-2008 | Dunkirk, MD 21 Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A. sta 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and De MYOCARDIAL Immediate Cause (Final 12 HRS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for as a consecuence of Examine The law requires that the death certificate be execute Due to (or as a consequence of): attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTELBION 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 XNo the Hospital or Attending Physician; filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 3 DOA P 1 ☐ Yes 2 ER/Outpatient this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Registrar DHMH 17 Rev 1/2001

State

within 24 hours a To the Funeral I

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)
FFR 7 2008

30. Name an address of person who co

Baltimore, Maryland 21215-0036

Box 68760.

o

Division or Vital Records.

mpleted cause of death (Item 23a) (Type, Print) KELSON BENJERY, 9131 PLYCHT AWM RD, CLINTON,

32. Registrar's Signature

🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

28281

29d. Date signed (Month, Day, Year)

2008

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Vear **Physician** 11:10 P M February 3, 2008 James E. Cundiff /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days 1 M 2 □ F Sep. 19, 1922 Virginia Director 85 228-16-0389 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy fujury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 tryes 2 □ No Director Washington DC N/A 10g. Citizen of What Country? 10e. Street and Number U.S. 20011 61 Longfellow St., N.W. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 5+ Librarian Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mildred Clement 2 Arthur Cundiff 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 61 Longfellow St., N.W. Washington, D.C. 20011 Lisa McCurdy / Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 2/9/2008 4 Donation 5 Dother (Specify) Washington, D.C. Rock Creek Cemetery 22. Name and Address of Facility McGuire Funeral Service, Inc. 21. Signature of Funeral Service Licenses gnice 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760× Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Yes 2 No P.O. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown Stroke, Parkinsonism 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Chronic Kidney Disease 24a. Was an autopsy performed? Yes 21 No 1□ Yes Non Insulin Dependant Diabetes Mellitus or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death al or Attending F after death. Division Injury 5 Pending investigation 1 🙀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 4, 2008 D37891 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A Rajvanshi, M.D. 121 Congresanal Lane # 409 Rockville, MD 20852 32. egistrar's Signature 31. Date filed (Month, Day, Year) FEB 0 7

State

Registrar

TAMES

CUNDEFF,

2008

| | | | 1 - For State Registrar | State of Mary | | ertificate of | | | g. No. 2 () | 08 | 0532 | 1 |
|-------------------|--|-----------------------|---|--|-------------------------------|---|---|---|--------------------------------------|-------------------------|---|------|
| | Di visi | | 1. Decedent's Name (First, Middle, La | st) | | | | 2. Date of Deat Month | | Year | 3. Time of Death | _ |
| | Physicia /Medic | | Joseph Francis | Costello | | | | February | | | 3:05 | þ |
| | Examin | er | 4a. Facility Name (If not institution, giv | | | | r Location of Death | | 4c. County of | | | |
| | | | Stella Maris Nurs 5. Social Security Number 6. S | | n yrs. last birthday | Timor | 11um If Under 24 Hrs. | 8. Date of Birth | 1 | | imore | חל |
| ∜ 2. a | Funeral Director | | , | X M 2 F | 91 Yrs. | Months Days | Hours Min. | Jan. 29 | Year) , 1917 | New | lace (State or Foreig htry) Jersey | 11.5 |
| | land ow | | 10a. State 10b. County | 10 | c. City, Town or L | ocation | | | | 10 | 0d. Inside City Limits | s |
| | Mary F-f sh | tor | Maryland | Montgomery | 7 | Rockville | <u> </u> | | | | 1 ☐ Yes 2 🛣 No |) |
| | or 28, |)ire | 10e. Street and Number | | | 10f. Zip Code | | 10 | 0g. Citizen of W | hat Coun | itry? | |
| 21215-0036 | 23a ust b | ral | 11101 Waycroft | | | 20852 | | | USA | | | |
| | er de | nne | 11. Marital Status | 12. Was Decedent Eve Armed Forces? | r in U.S. 13 | . Was Decedent of H If Yes, specify Cub | lispanic Origin? (Sp an, Mexican, Puerto | ecify Yes or No- Rican, etc.) | | - America , White, e | an Indian, etc. | |
| | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | d by Funeral Director | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | MXYes 2 ☐ No If Yes, Give Year or Dates: | WII | 1 ☐ Yes 2 📆 No | Specify: | | Specify: | | ite | |
| 5- | "natu | lete | 15. Decedent's Ed (Specify only highest gra | ducation ade completed) | 16a. Dec | edent's Usual Occup re kind of work done DO NOT use retired | oation during most of work d) | ing | 16b. Kind of Bus | iness/Ind | Justry | |
| 12 | withir ene. than he Me | Completed | Elementary/Secondary (0-12) | College (1-4or 5+) | | Agent | 4) | | Life | Insu | rance | |
| 0 0 | filed Hygi other ent, ti | č | 17. Father's Name (First, Middle, Last, |) | | 190110 | 18. Mother's Nam | e (First, Middle, N | | | Larice | |
| an | ald be fental rked o | To Be | Charles Costello |) | | | Edith K | ent | | | | |
| Maryland | shou and M s mai | | 19a. Informant's Name/Relationship (| Type. Print) | 19b. Mai | ling Address (Street | and Number or Rui | ral Route Number | City or Town, S | State, Zip | Code) | |
| Σ | and 2 ealth n 27 I | | Margaret Cassidy | | | 11101 Wayo | | | | | | |
| ore | ges 1 t of H If iter or oth | | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ | | cemetery, cr | oosition (Name of ematory or other pla | i | • 5, | 20c. Location - 0 | • | • | |
| Ë | tmen tant: | | 4 Donation 5 Other (Specif | y) | | litan Crem | 1 - | | | | Virginia | |
| Baltimore, | Depar Depar Impor Impor Impor Impor Impor | | 21. Signature of Funeral Service Licer | tel Op | | 22. Name and Addre | | | | | | |
| | | - 10 | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 500 University Blvd, W, Silver Spring MD 20901 Approximate Interval Between | | | | | | | | | |
| | Di | 10 | shock, or heart failure. List only one cause on each line. Interval Between Onset and Death | | | | | | | | | |
| | And the price of t | | disease or condition resulting in death) | a. Ischemic Due to (or as a co | Cardiomy | opathy | | | | | | _ |
| | | | | b. Congestiv | | | | | | | | |
| | | ner | Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that imitated events C. Atrial Fibrillation | | | | | | | | | |
| | | ami | Cause (Disease or injury that initiated events resulting in death) Last C. Atrial Fibrillation Due to (or as a consequence of): | | | | | | | | | |
| 90, | oe exician a | ũ | | | | | | | | | | |
| 68760, | physic the b | Medical Examiner | | d | | | | | | | | |
| × | The law requires that the death certificate be executed ite has been signed by the attending physician and page 2 should be detached for use as the burial-transit | /Me | IF FEMALE: | 23c. If yes, outcome pf p | oregnancy | | | | 23d. Date | of delive | erv | |
| .O. Box | w requires that the death cer been signed by the attendir should be detached for use | Physician/N | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No | 1 ☐Live birth 2 ☐ 4 ☐ Pregnant at tim | | ☐Ectopic pregnanc | у | | Mor | | Day Year | |
| oj. | t the o | hysi | 9 Unknown | 9□Unknown | | | | | | | | _ |
| S, | ss tha gned | by P | Part II. Other significant conditions | contributing to death but n | ot resulting in the | underlying cause giv | en in Part I. | 23e. Did tob | oacco use contri | bute to th | he cause of death? | |
| ğ | equire en siç ould b | ed | | | | | | 1 □ Y€ | es 2□ _K No | 3 Prob | ably 4 □Unknow | n |
| Records, | law ras be | Completed | | | | | | 24a. Was a | | Vere auto | ppsy findings availabl impletion of cause of | le |
| <u>~</u> | : The | Con | | | | | | perform 1□ Yes | | eath? Yes | 2 □ No | |
| Division or Vital | Physiclan: r this certific ral director, I | Be | 25. Was case referred to medical examiner? | Hospital: | | ont 3 DOA Oth | or. | th (Check only on | | | | _ |
| o | Phys r this ral dir | ٠ <u>۲</u> | 1 ☐ Yes 2 🔀 No 27. Manner of Death | 1 ☐ Inpatient | 2 ER/Outpati | elit 3 DOA | 4 LANursing H | ome 5 Reside | | | y) | _ |
| on | Attending r death. ector: After by the funer | Certification: | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Y | | Wo | rk? Yes 2∐No | | ,, | | | |
| /ISI | Atten r deat ector | fica | 3 Suicide 6 Could not b 4 Homicide determined | e 28e. Place of injury | - At home, farm, s | street, factory, office | | 28f. Location (St | reet and Numbe | er or Rura | al Route Number, | |
| Ó | al or s afte al Dir | Sert | 4 Homicide | building, etc. (| specify) | | | City or Towr | n, State) | | | |
| | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Medical (| 29a. Certifier (Check only one) 1 CertifyIng Pt 2 Medical Example 1 | nysician: To the best of n niner: On the basis of ex and manner stated | amination and/or | ath occurred at the ti investigation, in my | me, date and place opinion, death occu | , and due to the c rred at the time, d | ause(s) and mai late and place, a | nner as s | tated. o the cause(s) | |
| | To th within To th | Me | 29b. Signature and title of dertifier | | | 29c. Licens | se number | 2 | 9d. Date signed | (Month, | Day, Year) | |
| \ | | | Mary Wan | | | M | ID52247 | | Febru | ıary | 6, 2008 | |
| 1 | DXI | | 30. Name and address of person who Collin D. Cullen, | | h (Item 23a) (Type Wiscons | e, Print) Sin Avenue | e, #101, I | 3ethesda | , MD 208 | 3 14 | | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) FEB 0 7 2 | 32. Pegistrar's | Signature | Conti | - | | | | | |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 5, Day 2008 ear **Physician** FEB. 10:50A M LUZ M. CASTILLO-ULLAURI /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY Hebrew Home Rockville Under 1 Year If Under 24 Hrs. onths Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday Social Security Number 6. Sex **Funeral** Days 1 T M 2 X F 223-75-3607 77 Mar. 10, 1930 Ecuador Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show r 28a-f show notified at tyE Yes 2 □ No Director Berkely Hedgesville 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number o e 25427 68 Ivanhoe Drive Ecuador ms 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or items dical Examiner mo 11. Marital Status and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 XYes 2□ No Specify: Spanish Spanish þ 3x Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6th Housewife Home nt of Health and Mental Hygis I fitem 27 is marked other or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Aurelio Castillo Rosa Lastenia Ullauri 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rosa Yanez (Daughter) 68 Ivanhoe Dr, Hedgesville, WV 25427 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Park Crem 2/6/08 Riverdale, MD 4 □ Dephation 5 □ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. art1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heal failure. List only one cause on each line. 246 N. Washington St, Rockville, MD 20850 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner -EBRAL ATHE ROSCLEROSIS 12 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9⊡Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed DEMENTA 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performe To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie FEBRUARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 121 MONTROSE NESH 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 07 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** DOSHIA COLEMAN **FEBRUARY** 3 2008 2:00 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MANOR CARE NURSING HOME LARGO PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) 94 Yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1XM 2□F GEORGÍA NOV. 27 1913 Director 252-32-9081 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No GLENN PRINCE GEORGE'S DALE MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20769 USA 9701 HARBOR AVENUE Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 12TH HOUSEWIFE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY GRIER FORD ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9701 HARBOR AVENUE GLENN DALE, MARYLAND 20769 RUDOLPH COLEMAN/SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State RESURRECTION CEMETERY 2/11/2008 CLINTON, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee Mach 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) INFECTED DECUBITUS ULCER **Physician** /Medical Due to (or as a consequence of): Examiner DEEP VEIN THROMBOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed DIABETES MELLITUS and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1∐ Yes 21X No the Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🔀 No Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

D0062116

7705 BELLEPOINT DRIVE GREENBELT, MARYLAND

FEBRUARY 6, 2008

20770

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MEKLIT WORKNEH M.D.

31. Date filed (Month, Day, Year) FEB 0 8 2008

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 05327Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 6:24 P™ 02/01/2008 Jacqueline Cales /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Prince George's Bowie Health Center Bowie If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2€X Months 39 Director 217-08-1471 12/14/1968 Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 XX es 2 □ No Directo Prince George's Bowie Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 20715 U.S.A. 7905 Orchard Parkway Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XXNo If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. e filed within 72 hours after of all Hygiene. I Other than "natural", or iter 1 ☐ Never Married 2 XX Married 1 ☐ Yes 2 No White altimore, Maryland 21215-0036 Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Federal Courts Court Deputy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill h and Mental H 7 is marked oth Department of Health and Merinimportant: If Item 27 is any Injury or other Be James Edward Prather Dorothy Barbour 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Cales/Husband 7905 Orchard Parkway Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakemont Memorial
Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XX urial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/09/2008 Davidsonville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final **Physician** ardia hour disease or condition resulting in death) /Medical Due to (or as a consequence of): eart disease Examiner ongeni Sequentially list conditions Jue to for as a consequence of): Physician/Medical Examiner if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records. been signe should be d Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has autopsy performed? /es 2 No certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred After s after dear-1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital within 24 hours To the Funeral Medical 29a. Certifier 1 🕇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. noletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. the 29b. Signature and title of certifier H0055542 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 888 Bestgate Road Annapolis/1021401 nson p: 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 0 6 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05328 Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year ARTER 3 3M /Medical 03 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Cranberry Cottage Assisted Living Arnold If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 10 M 2 🗆 F Days 85 Hours 216-14-7135 Director May 13, 1922 Maryland Usual Residence of Decedent a or 28a-f show the notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Arnold 1 ☐ Yes 2 No MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? r than "natural", or items 23a the M dI al Examiner must b USA 21012 186 Campus Green Drive Funeral within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Americen Indian, 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify \$ 3 Widowed 4 ☐ Divorced Specify: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore Gas & Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Electric Company permit. Pages 1 and 2 should be filed Department of Health and Mental Hygii Important: If item 27 is marked other any Injury or other traumatic event. It 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Violet Timlin UNK ၉ 19a. Informant's Name/Relationship (Type. Print)
Mary Priscilla Schneider/ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 928 Blue Ridge Drive Annapolis, Maryland 21401 Stepdaughter 20b. Place of Disposition (Name of cometery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition Date 05, 20c. Location - City or Town, State Feb. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Timonium, Maryland 21. Signature of Poneral Service Lensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** len /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): law requires that the death certificate be executed Cause (Disease or inju-that initiated events resulting in death) Last burial-tran and Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the attending p as IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death signed by the a 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ð 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an has e 2 autops page certificate 1☐ Yes Physician: 25. Was case referred to medical examiner? director. Be ANBERRY 26. Place of Death Check onl one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 No COTTAGE Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 Residence Other (Specify) 28a. Date of Injury (Month, Day funeral 27. Manner of Death # SALF 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29b. Signature and title of certific

State Registrar

31. Date filed (Month, Day, Year) FEB 0 6 2008

32 Registrar's Signature

M

atent

m

mpleted cause of death (Item 23a) (Type, Print)

445

Speck

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year Michael Edward /Medical Dyson February 9. 2008 7:00 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 13486 Dyson Place Charlotte Hall Charles Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 **3** M 2 □ F Director 219-58-8965 56 April 20,1951 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show Lry or other traumatic event, the M. Alcal Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No Maryland Charles Charlotte Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13486 Dyson Place by Funeral 20622 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry CPF Underground Elementary/Secondary (0-12) College (1-4or 5+) Utilities Surveyor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Ellsworth 2 Dyson Martha Lucille Burroughs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Sandra M. Dyson/Spouse 13486 Dyson Place, Charlotte Hall, MD 20622 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/11/2008 | Charlotte Hall, MD Brinsfield-Echols 21. Signature of Funeral Service Licens 22. Name and Address Brinsfield-Echols Funeral Home, P.A. 30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 P 23a. Part1. Enter the disease shock, or heart failure. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ecurent Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): physician Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by

Physician /Medical **Examiner**

Baltimore, Maryland 21215-0036

Box 68760

1 XYes 2 No 3 Probably 4 Unknown 24a. Was an

1∐ Yes 2X No 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Tyes

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation

28c. Injury at Work? Injury 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month. Day, Year)

29a. Certifier and manner stated.

6 ☐ Could not be

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ralifornia, mo 20619

2008 1



ORIGINAL

29c. License number

D0062288

Division or Vital Records, P.O. To the Hospital

or Attending Physician: within 24 hours after deau.

To the Funeral Director: Aft

Be

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1 ☐ Yes 2 🔀 No

27. Manner of Death

1 Natural 2 ☐ Accident

3 Suicide

29b. Signatur

4 Homicide

Uppa

31. Date filed (Month, Day, Year)

Certification: Medical

State Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 10:20 AM Thelma Jane Doyle February 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis 4 8 1 Anne Arundel 8. Date of Birth (Month, Day, Year, 9/14/1929 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F 402-38-0717 78 Kentucky Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Anne Arundel Davidsonville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3748 Coronada Rd. 21035 **IISA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: 1950–52 Specify Specify. ģ 3 □ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the vears Homemaker Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Curtis Miller Syothia Goodpasture 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorne E. Doyle/ Husband <u>3748 Coronada Rd., Davidsonville, MD 21035</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 A Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery 2/6/08 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signator of Funeral Service 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any scaling of the cause cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed (NEURYSAS and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 88 attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 DNo
9 Unknown 4☐Pregnant at time of death 5 Other (specify) þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA P this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No ₽ ☐ Accident 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of of 10060752 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Garth A. Ashbeck, M.D. 277 Peninsula Farm Rd., Arnold, MD. 21012 31. Date filed (Month, Day, Year) 32. Egistrar's Signature State FEB 0 6 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Kennith E. Edward 2008 February 4. /Medical 12:45 P. 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Prince George's Hospital Center Cheverly Prince George's Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours TVZ M 2□ F 577-84-8801 Director 41 Washington, D.C. November 7, 1966 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Examiner must be notified at D.C. 1 Yes 2 No Washington Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō U.S.A. 3960 Ames Street, N.E. items 23a 20019 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🛣 No Specify: þ 3 Widowed 4 Divorced Black Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Short Order Cook 12th grade is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental H litem 27 is marked otl r other traumatic ever Robert Rosevelt Edmond ပ Emma B. Wright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sharon D. Hughes-Edmond(Wife) 3960 Ames Street, N.E. Washington, D.C. 20019 20b. Place of Disposition (Name of cemetery, crematory or other place)
Resurrection Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot once. February 12, 2008 Clinton, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 23a. Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest not k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death imminiate Cause (Final Respiratory/Cardiac Arrest Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Severe Depression Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Severe Arthritic Disorder Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performe 2 🛛 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2X ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 X Natural within 24 hours arter con-5 ☐ Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

DHMH 17 Rev 1/2001

State

29b. Signature and title of contifie

31. Date filed (Month, Day, Year)

FEB 1 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Emmanuel T. Munlangu, M.D. 106 Irving Street, N.W. Suite #403 Washington, D.C. Date filed (Month, Day, Year) 32. Registrar's Signature

29c. License number

MD21791

29d. Date signed (Month, Day, Year)

February 8, 2008

| | | | 1 For State Registrar | State of Maryla | | artment of He rtificate of D | | | | 00006 | | |
|---|---|----------------|--|---|---------------------------------|--|---|------------------------------------|----------------------------------|--------------------------------------|--|--|
| | | | Decedent's Name (First, Middle, Last | t) | | rimodio or B | | . Date of Death | , No. | 3. Time of Death | | |
| | Physici | | MARY LOU EWING | | | | R. | Month EBRUARY | 3 2008 | 10:28 PM | | |
| | /Medi Examir | | 4a. Facility Name (If not institution, give | street and number) | | 4b. City, Town, or L | | LDNOM | 4c. County of Death | | | |
| | | | RUXTON HEALTH OF D | | | DENTON | If Under 24 Hrs. g | | CAROLINE | | | |
| Г | Funeral Director | | 5. Social Security Number 6. So 1 | □M 2M F 7. Age (In yrs | s. last birthday, Yrs. | | Hours Min. | Date of Birth (Month, Day, Y | (ear) 9. Birth | place (State or Foreign ntry) RYLAND | | |
| | | | Usual Residence of Decedent | | | | PI | BRUARY 28 | 0, 1930 FA | (ILAND | | |
| | nylane how | | 10a. State 10b. County | 10c. C | City, Town or L | ocation | | | | 10d. Inside City Limits | | |
| | ith the Marylar or 28a-f show | Director | MARYLAND CAROLINI | | GOLDSBO | RO | | | | 1 ☐ Yes 2X No | | |
| | or 2 | E. | 10e. Street and Number | | | 10f. Zip Code | | 10g | . Citizen of What Cou | intry? | | |
| | s 23a | rai | 14762 DAY ROAD | 40.00 | | 21636 | | | NITED STAT | | | |
| | after death w or Itams 23a | Funerai | 11. Marital Status 1 □ Never Married 2 □ Married | 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 ☒ No | 0.8. | Was Decedent of Hisp If Yes, specify Cuban, | anic Origin? (Specif Mexican, Puerto Ric | y Yes or No- can, etc.) | 14. Race - Ameri Black, White | | | |
| 99 | ours after death with the Maryla ral', or Itams 23a or 28a-1 sho Ever in vermal be redified at | by | 3 Widowed 4 Divorced | If Yes, Give Year or Dates: | | 1 ☐ Yes 2 🙀 No | Specify: | | Specify: | HITE | | |
| 21215-0036 | within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show he Medical Evar, in et in ust be rediffed at | Completed | 15. Decedent's Ed (Specify only highest gra | ucation | 16a. Dece | dent's Usual Occupation | on | 16 | ib. Kind of Business/Ir | ndustry | | |
| 2 | ithin nan "i | npie | Elementary/Secondary (0-12) | College (1-4or 5+) | life. | DO NOT use retired) | ing most of working | | | | | |
| 2 | filed w Hygier other th | S | 12 | | HOM | EMAKER | G 14 11 1 11 17 | | OWN HOME | | | |
| Maryland | 2 should be filed withir and Mental Hygiene. is markad other than aumatic avant, Ite Ms | Be | 17. Father's Name (First, Middle, Last) | | | " | 8. Mother's Name (F | | iden Sumame) | | | |
| 2 | shoutd I nd Meni marka umatic | 2 | LEMUEL GARDNER 19a. Informant's Name/Relationship (7 | voe Print) | 19h Maili | ng Address (Street and | MARY SMIT | | City or Town State 7 | n Code) | | |
| Ma | | | MARY RAE EWING/DA | | | 2 DAY ROAD | | | | | | |
| ē, | f Health item 27 othar tr | | 20a. Method of Disposition | 206. | Place of Dispe | osition (Name of matory or other place) | Date | 20 | c. Location - City or T | | | |
| E | | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | | LLE CEMETE | FEBRUA ERY 2008 | | FUENCUTTI | E. MARYLAND | | |
| altimore, | permit. Pages 1 and Department of Health Important: If item 27 any injury or other to once. | | 21. Signature of Funeral Service Licen. | | 2 | 2. Name and Address | of Facility | | 91 23 | | | |
| 8 | 89 7 8 8 | | (per | ter | RO I | 16 SHAMROCH | ROAD, CH | IND NEWN IESTER. | MARYLAND | BOME, P.A. | | |
| | | | 23a. Part1. Enter the disease of comp shock, or heart failure. List only of | i, | Approximate Interval Between | | | | | | | |
| | Prysician | | Immediate Cause (Final disease or condition | a Renal | fail | wre | | | | Onset and Death | | |
| 1 | /Medical Examiner | | resulting in death) | Due to (or as a conse | equence of): | | | | | | | |
| | | 20 | Sequentially list conditions, | if any, leading to immediate Due to (or as a consequence of): | | | | | | | | |
| | uted J ansit | Examiner | Cause (Disease or injury | end 51 | | Deme | a Lan | | | | | |
| o, | be executed sician and burial-transit | Еха | that initiated events resulting in death) Last | | | | | | | | | |
| 68760, | ificate be executed g physician and as the burial-transit | edicai | | d. | | | | | la la | | | |
| | nd ph ng ph s as th | | IF FEMALE: | | | | | | | | | |
| Box | leath certii attending I for use a | lan/I | 23b. Was decedent pregnant | 23d. Date of delivery | | | | | | | | |
| 0. | The law requires that the death cert tte has been signed by the attendin vage 2 should be detached for use | Physician/M | in the past 12 months? 1 | | | | | | | Month Day Year | | |
| ۵. | that the ed by detac | | Part II. Other significant conditions co | 23e Did tohac | co use contribute to I | he cause of death? | | | | | | |
| ds, | signe d be | d by | 3 | | | riconying oddoo givon | iii i ditti. | 1 □ Yes | | bably 4 □Unknown | | |
| Vital Record | w requir been si should | Completed | | | | | | 24a. Was an | 24h Wara aut | ppsy findings available | | |
| Re | The lav | ртс | | | | | | autopsy performed | d? prior to co | impletion of cause of | | |
| tal | (0) 1-4 | a) | 25. Was case referred to medical | | | 20 | 6. Place of Death (C | 1 Yes 2 | 1 ☐ Yes | 2∐ No | | |
| Ž | d s | To B | examiner? 1 □ Yes | Hospital: 1 ☐ Inpatient 2 ☐ | ER/Outpatier | Othor | 7.5 | | e 6 Other (Speci | fy) | | |
| n of | fe fe | | 27. Manner of Death Satural 5 Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time o | 28c. Injury at Work? | | l. Describe how | | | | |
| Sio | Attanding or death. ector: After by the fune | cati | 2 Accident investigation 3 Suicide 6 Could not be | | | M 1 ☐ Yes | s 2 🗆 No | | | | | |
| Division | 5. 5. # ¢ | Certification: | 4 Homicide determined | 28e. Place of Injury - At I building, etc. (Spec | nome, farm, str ify) | eet, factory, office | 28f. | Location (Stree City or Town, S | et and Number or Run State) | al Route Number, | | |
| | Hospital 14 hours a Funaral 1ely filled | | 29a. Certifier Certifying Phy | sician: To the best of my kn | outodas dost | h opportunit at the time | data and alass and | | | | | |
| | 24 hos 24 hos a Fun etely | edicai | (Check only 2 Medical Exam | ner: On the basis of examin and manner stated. | ation and/or in | vestigation, in my opini | ion, death occurred | at the time, date | and place, and due t | o the cause(s) | | |
| and manner stated. 29c. License number 29d. Date signed (Month, Day, Yea. | | | | | | | Day, Year) | | | | | |
| | 2 | | | | IND | 0005 | 3255 | | 2/4/20 | 008 | | |
| | ars | | 30. Name and address of person who co | ompleted cause of death (Ite | m 23a) (Type, | | | | | | | |
| | IV | | Melinda Bu | ther 136 L | | m Are | Yresto | n W | 0 2165 | 5 | | |
| | Sta | - | 31. Date filed (Month, Day, Year) | 32. gistrar's Sign | -4 | | | | | | | |
| | Registr | ar | FEB - 5 21 | JUB DEMEN | D 19 | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FEB. **Physician** Carl Leon Fluharty $1\overset{\text{Day}}{1}$, 2008 12:10p м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Denton Caroline Caroline Home for Hospice If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 1, 1941 9. Birthplace (State or Foreign **Funeral** 216-38-8067 1**X**□XM 2 □ F Maryland 66 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at show MDCaroline Federalsburg 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a 3469 American Corner Road 21632 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. I □ Yes 2 📉 No f Yes, Give ⁄ear or Dates: 1 Never Married XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X ☐ MNo White Specify þ Specify: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Trucking Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Fluharty, Roberta Handy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21632 19a. Informant's Name/Relationship (Type. Print) 3469 American Corner Rd., Federalsburg, Elizabeth Ann Fluharty/Spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Junior Order Cemetery 02/15/08 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Preston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) months /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trag Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the as attending | IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No signed by the a 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ② Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b irector, page 2 s perform 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dire ² 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician. Medical To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

FEB 1 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Exam

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



AS

ro the

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

29c. License number

DHMH 17 Rev 1/2001

| | | | For State Registrar | State of Ma | | Department of H Certificate of L | | | jiene _{eg. No} 2008 | 05335 | | | | |
|----------------|---|------------------|--|--|-----------------------------------|---|--|--|---|---|--|--|--|--|
| r | Physici | 20 | 1. Decedent's Name (First, Middle, La | | | | | 2. Date of Dea | Day Year | 3. Time of Death | | | | |
| | /Medic | al | MARIE H. | | SEV0ETS | 4h. City. Town, or | Location of Death | February | / 6 2008 4c. County of Dea | 10:25 P M | | | | |
| | Examin | er | MORNINGSIDE HOUS | | | | OTT CITY | | HOWARI | | | | | |
| | Funeral Director | | 5. Social Security Number 125–30–5995 | Sex 7. Age 1 □ M 2 X F | (In yrs. last birt | thday) If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day Feb. 12 | (Year) C | rthplace (State or Foreign Country) Belgium | | | | |
| | land ow tf | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town | or Location | | | | 10d. Inside City Limits | | | | |
| | e Mary a-f sh tified a | ctor | Md. Montg | omery | Lā | aytonsville | | | | 1 □Yes 2 X No | | | | |
| | th with th 23a or 28 ist be no | Funeral Director | 10e. Street and Number 21734 Mobley Far | m Drive | | 10f. Zip Code | 20882 | 1 | Og. Citizen of What C United S | | | | | |
| 215-0036 | be filed within 72 hours after death with the Maryland Ital Hygjene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at | þ | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates: | | 13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No | ispanic Origin? (Sp an, Mexican, Puerto Specify: | ecify Yes or No- Rican, etc.) | 14. Race - Arr Black, Wh Specify: | | | | | |
| <u>2</u> | "natur | letec | 15. Decedent's E (Specify only highest gr | | | Decedent's Usual Occup. (Give kind of work done of life. DO NOT use retired | ation during most of work | king | 16b. Kind of Busines | s/Industry | | | | |
| 717 | filed within 72 Hygiene. vther than "na ott, the Medic | Completed | Elementary/Secondary (0-12) | College (1-4or 5- | +) | Cook | , | | U.S. Gove | rnment | | | | |
| | | Be | 17. Father's Name (First, Middle, Las. Louis Dubois | ") | | | 18. Mother's Nam Brigit | | Maiden Surname) steloot | | | | | |
| Maryland | s 1 and 2 should I if Health and Men Item 27 Is marker other traumatic | ဠ | Louis Dubois 19a. Informant's Name/Relationship | | Zip Code) | | | | | | | | | |
| | and 2 sealth ar | | Nadine Hasevoets-Tarwater/Daughter 21734 Mobley Farm Dr., Laytonsville, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Townson 20c. Location - City or T | | | | | | | | | | | |
| galtimore, | permit. Pages 1. Department of He Important: If Iten any Injury or oth | | | | 20c. Location - City of Silver Sp | | | | | | | | | |
| Balt | permit. Departr Importa any Inju | | 21. Signature of Funeral Service Lice | gnature of Funeral Service Licensee Muriel H. Barber Funeral Home P. O. Box 5038, Laytonsville, Md. 20882 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between | | | | | | | | | | |
| | Physician | | Immediate Cause (Final | Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. diate Cause (Final se or condition ing in death) a. Althroscients Carico Vacular Difference Due to (or as a consequence of): | | | | | | | | | | |
| | /Medical Examiner | | resulting in death) | ase or condition (lting in death) Due to (or as a consequence of): b. Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | |
| | LXammer | er | Sequentially list conditions, if any, leading to immediate | | | | | | | | | | | |
| | ecuted and transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | |
| 8/60, | cate be executed physician and the burial-transit | | Due to (or as a consequence of): | | | | | | | | | | | |
| 9 | | Medical | IE EENALE. | - U | | | | | | | | | | |
| C. Box | the death certifi y the attending I ched for use as | Physician/Me | F FEMALE: 23b. Was decedent pregnant in the past 12 moeths? 1 Yes 2 No 9 Unknown 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23d. Dat Mo 23d. Dat Mo 23d. Dat 24d. Dat 24d. Dat 24d. Dat 24d. Dat 24d. Dat 24d. Dat 24 | | | | | | | elivery Day Year | | | | |
| S, | res that the de signed by the a be detached f | by Ph | Part II. Other significant conditions | contributing to death bu | rt not resulting in | n the underlying cause giv | en in Part I. | | | to the cause of death? | | | | |
| ord | w require been sig should b | | | | | | | 1 U Y | 7 | 12. | | | | |
| Vital Hecords, | The la | Completed | | | | | | 24a. Was a autop perfor 1□ Yes | sy prior to | | | | | |
| | slclan certifi irector | Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No | Hospital: | nt 2∏ER/Ou | tpatient 3 DOA Oth | er. | th <i>(Check only o</i> ome 5 ☐ Resid | | Assisted Decify) Living | | | | |
| פֿר | ding Phys n. After this funeral di | n: To | 27. Manner of Death | 28a. Date of Injur (Month, Day | y 28b. | Time of njury 28c. Injur | | | ow injury occurred | becity) = V · · · · · · · · · · · · · · · · · · | | | | |
| DIVISION OF | tendin leath. tor: Af the fur | catio | 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not it | on . | | M 1 | Yes 2 □ No | OOF Leasting (C | treet and Number or | Direct Davids Museline | | | | |
| <u>></u> | al or A | Certification: | 4 ☐ Homicide determined | building, etc | c. (Specify) | ırm, street, factory, office | | City or Ton | n, State) | nulai nulle Nullibel, | | | | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, to | Medical C | (Check only 2 Medical Exa | miner: On the basis of | examination ar | e, death occurred at the tind ad/or investigation, in my o | pinion, death occu | irred at the time, | date and place, and d | lue to the cause(s) | | | | |
| } | To the within To the comp | M | 29b. Signature and title of certifier 2 | | | 29c. Licens | e number 3064 | .1 | 29d. Date signed (Mo | nth, Day, Year) 1 7 2008 | | | | |
| | 4 | | Ramal Saba | pathi a | eath (Item 23a) | (Type, Print) Back Ru | red New | L Road | 1 Bal | Johnny Manley | | | | |
| | Sta Registi | | 31. Date filed (Month, Day, Year) | 32. Regist | ur's Signature | & Specter | | | | 212 | | | | |
| | | - 1 | EER T | T Coho , To | THE REAL PROPERTY. | | | | | | | | | |

DHMH 17 Rev 1/2001

State

Registrar

PIOTR L. GROJEC M.D.

31. Date filed (Month, Day, Year)

FEB 0 8 2008

32. Registrar's Signa

6400 MARLBORO PIKE DISTRICT HEIGHTS, MARYLAND 20747

amend line 18 per fd aaco hlth dept 02/11/08 dlw amend line 4b per me aaco hlth dept 02/06/08 dlw 08-00909 Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 05337 Sally Barbara Hall 1- For State Certificate of Death Reg. No Registrar

1. Decedent's Name (First, Middle,Last) 3. Time of Death 2. Date of Death Physician/ Month Day February 1, 2008 1715 hrs Sally Barbara Hall Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Anne Arundel 642 Broadneck Road Annapolis If Under 1 Year | If Under 24Hrs. | 8, Date of Birth (MM/DD/YYYY) | 9, Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number Foreign Countr**Wirginia** Funeral Months 6/17/1933 227-42-7971 74 Director Yrs 2 X F Usual Residence of Decedent 10d, Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2XX No Annapolis Maryland Anne Arundel 28a-f show s 23a or 28a-f show e notified at once, Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21409 642 Broadneck Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11 Marital Status ilmore, MD 21215-0036

Pages 1 and 2 should be filed within 72 hours after death wit ment of Health and Mental Hygiene.
Titien 21 is marked other than "natural", or items 2 or other transmatic event, the Medical Examiner must be 1 or other transmatic event, the Medical Examiner must be 1 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 Married Yes 2 X No White Specify Divorced If Yes, Give Year Yes 2XX No specify: ð 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alva Sturgill Alva Gardner Coy Bowman Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1352 Poplar Hill Drive Annapolis, MD Teresa Sullivan/daughter 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a Method of Disposition fimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Hillcrest Mem. Gardens 2/6/2008 Annapolis, Maryland permit. Pages
Department of
Important: I Donation 5 Other Specify 22. Name and Address of Facility John M. Taylor Funeral Home 21. Si of Funeral Service Licensee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Diabetic ketoacidosis complicated by hypothermia Between Onset and Physician Death a. Athereseleretie Cardiovascular Disease and Head And Torse injuries Medical Immediate Cause (Final disease *x*aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - transit The law requires that the death certificate be executed Physician/Medical X 4#232,pII, perME,g877 3/6/08 TI UNPENDED 23d. Date of delivery Box 68760 23c. If yes, outcome of pregnancy IF FEMALE Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 ✔ No 9 Unknown Unknown ched 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the bedetache o 1 Yes 2 V No 3 Probably 4 Unknown ģ Records, P. Probable hypothermia Completed s been signated b 24b. Were autopsy findings available 24a. Was an Atherosclerotic cardiovascular disease, head and torso injuries prior to completion of cause of death? autopsy performed? has 1 🗸 Yes 2 No ✓ Yes 2 certificate 26.Place of Death (Check only one) 25. Was case referred to medical fo the Hospital or Attending Physician: Division of Vital Be Hospital: examiner? Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 DOA Inpatient 2 this 1 🗸 Yes No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) FOUND: After 27. Manner of Death Subject with probable fall and exposure to cold Certification: **FOUND** Natural 1 Yes 2 ✔ No 5 Pending environmental temperatures within 24 hours after death.

To the Funeral Director: Feb 1, 2008 1700 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be or Town, State) 642 Broadneck Road, Annapolis, MD 3 Suicide determined (Specify) Single Family 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 2, 2008 O.C.M.E. outhall MD 30. Name an last less of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Pamela E. Southall, MD 32. Re strar's Signature 31. Date filed (Month, Day, Year) 2008 Registrar

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person Anjum Qazi, M.D.,

31. Date filed (Month, Day, Year)

FEB

07

2008

completed cause of death (Item 23a) (Type, Print)

7610 Carroll Avenue, Takoma Park, Maryland 20912

Box 68760 Records, P.O. Division or Vital

| | | | ype or Prin State of Ma | | | | | | | _ | | _ | jible. |
|--|--|---|--|----------------------------------|--|----------------------------------|------------------------|---|------------------------|-------------------------------------|--------------------|----------------------|--|
| - | 1 | For State Registrar Amended item 1. Decedent's Name (First, Middle, Last) | #5 per fl | n | | | | Death _C | CHD | AS 2-5 | Feat M | | 008 053 |
| hysician /Medical | | Herbert Euge | ene Ive | ns | | | | | | 2. Date of De Month | eath 214 | SIs. | 3. Time of Death |
| Examiner ineral rector | 4 | 5. Social Security Number 6. Sex | ital at | e (In yrs. l | s ton ast birthday) Yrs. | | Eas- er 1 Year | r Location of E | Hrs. 8 | B. Date of Bir (Month, Da | th av. Year | u. Coulli | ty of Death Talbo+ 9. Birthplace (State or Fo Country) Pennsylvani |
| and second | - | Usual Residence of Decedent 10a, State 10b, County | | | , Town or Lo | cation | | | 7-1 | -2 - 7 | | | 10d. Inside City Li |
| iffed at | | Maryland Carol | Line | Ric | dgely | | | | | | | | 1 □ Yes 2 ½ |
| must be notified at leral Director | | 10e. Street and Number 11223 River Roa | ad | | | | ip Code 660 | | | | | itizen of SA | f What Country? |
| Examiner must | | 11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced | 12. Was Decedent & Armed Forces? 1 Yes 2 N IX Yes, Give Year or Dates: | | s. 13. 1 5 | Was Dec If Yes, sp 1 ☐ Yes | | lispanic Origin an, Mexican, F Specify: | n? (Speci Puerto Ri | ify Yes or No ican, etc.) |)- | | ace - American Indian, ack, White, etc. hity: White |
| t, the Medical E | - | 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) | cation completed) College (1-4or 5 | i+) | | kind of w DO NOT | ork done use retire | oation during most of d) Ctrici | | 7 | | | Business/Industry ruction/Ind |
| rtic event, ti | | 17. Father's Name (First, Middle, Last) Frank Ivens | | | FIUIII | ner/ | ьте | | Name (| First, Middle | , Maide | n Surna | ame) |
| her trauma | - 5- | 19a. Informant's Name/Relationship (Typ Mary C. Ivens/ v | | 1001 5 | 1 | 23 F | live | | | lidge | Ly, | Ma | n, State, Zip Code) ryland 2166 |
| any injury or other traumatic event, the Medical Examiner once. To Be Completed by Fun | | 20a. Method of Disposition | Commercial Commercia | | | | | | | | | | |
| prysidan and street street burial-transit and leading burial-transit and leading burial Examiner | | shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) | Due to (or as a A CU) Due to (or as a A CU) | ne. UZI a consequ E a consequ TE | C P lence of): CORO lence of): NON | ENA | 72 'Y, | FAIL. ARTEN | URE RIE | = 1 DI | 'SEI | 4 St | Onset and Deat |
| letached for use as the bearing Physician/Medica | | IF FEMALE: | 3c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown | 2 Fetal | death 3 |]Ectopic] Other (| pregnanc; specify) | y | | | | | Date of delivery Month Day Year |
| be o | | Part II. Other significant conditions con | tributing to death bu | ut not resu | lting in the u | nderlying | cause giv | en in Part I. | | | | | ntribute to the cause of death |
| rector, page 2 should | | | | | | | | | _ | 24a. Was auto perfo 1∐ Yes | psy ormed? | | Were autopsy findings avair prior to completion of cause death? □ Yes 2 ♥ No |
| director o Be | | 25. Was case referred to medical examiner? 1 Yes 2 No | ospital: | nt 2 🗆 I | ER/Outpatier | nt 3 🗆 🗀 | OA Oth | or: | | Check only | | 6 🗆 0 | other (Secrify) |
| on: | 1 Yes 2 No 1 Months 1 | | | | | | | | | | | | |
| completely filled in by the funeral Medical Certification: | | | | | | | | | | | | | |
| pletely file | | 29a. Certifier 1 □/Certifying Phys (Check only one) 2 □ Medical Examir | ician: To the best oner: On the basis of and manner sta | examinat | wiedge, deat ion and/or in | n occurre vestigation | d at the ti | me, date and popinion, death | place, ar occurred | nd due to the d at the time | cause(, date a | s) and n nd place | manner as stated. e, and due to the cause(s) |
| comp | | 29b. Signature and title of certifier | n | | | 2 | | e number 205942 | 87 | | 29d. D | ate sign | ned (Month, Day, Year) |
| State | | 30. Name and wdress of person who con John Botsis, M 31. Date filed (Month, Day, Year) | ID 219 S | | shine | rton | St | reet | Е | aston | ., M | 1D 2 | 21601 |

DHMH 17 Rev 1/2001

Registrar
DHMH 17 Rev 1/2001

PEB 14

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 5 **, Physician** 6:41P FEBRUARY 2008 HELEN JACOBS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY BETHESDA SUBURBAN HOSPITAL 8. Date of Birth (Month, Day, Year) 02/19/1912 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Days Months Hours Country) AUSTRIA 1 □ M 2 1 F 95 063-07-5820 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be proce. 10d. Inside City Limits 10c, City, Town or Location 1 X Yes 2 No Director POTOMAC MONTGOMERY MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20854 USA 9440 NEWBRIDGE DR #310 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married WHITE 1 Yes 2 No Specify: Specify þ 3X Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) BOOKKEEPER/OFFICE MANAGER REAL ESTATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NESIA REICH MOSES PADWA ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10204 COUNSELMAN ROAD, POTOMAC, MARYLAND JOAN BRAUNSTEIN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ABurial 2 □ Cremation JUDEAN MEMORIAL GDNS 02/08/2008 OLNEY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) re Funeral Service Licensee 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC
1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 21. Sign 14 20852 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) stroke **Physician** /Medical Due to (or as a consequence of) **Examiner** piratory Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as IF FEMALE. use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year Day for in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? ate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1☐ Yes certificate Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28h Time of 28c. Injury at Work? the Hospital or Attending 1 Natural 5 Pending investigation n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D065850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEENAKSHI GUPTA, 10 CENTER DRIVE, ROOM BID-733, BETHESDA, MARYLAND 20892-1063 31. Date filed (Month, Day, Year) State 0 7 2008 FEB Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 9:40 AM Feb 2008 Elizabeth Marguerite /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Genesis HealthCare - The Pines Easton If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F 212-16-1668 Director December 28, 1917 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 ☐ Yes 2 ☐ No Examiner must be notified by Funeral Director Caroline Denton Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code or items 23a 10774 Greensboro Road 21629 United States of America s 1 and 2 should be filed within 72 hours after death of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Marguerite Jump Baltimore, Maryland 21215-0036 Specify: Caucasian 1 ☐ Yes 2€20No 3. Note of the state of the st Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home 11 HS Grad Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian William Peregoy Twigg 2 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 51, Tilghman, Maryland 21671 Donna J. Harrison Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once, 1 □ Burial 2 □ Cremation 3 □ Removal from State 2/7/2008 Denton, Maryland Denton Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Moore Funeral Home, P.A. 21. Signature of Funeral Service Denton, Maryland 21629 South Second Street, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 414 Nursing Home 5 - Residence 6 - Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA s after death.

Il Director: After this c
d in by the funeral dire ျ 28a. Date of Injury (Month, Day Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral Completely filled is 冠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Name and address of person who completed cause of death (Item 23a) (Type, Print) 610 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 5 2008 DHMH 17 Rev 1/2001

RS 2

| J. Box 68/60, | | Baltimore, Maryland 21215-0036 |
|----------------------------------|--------------------|---|
| ne death certificate be executed | Phy /N Exa | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland |
| the attending physician and | /sic led ami | Department of negatification were a range in a partment of items 23a or 28a-f show |

| | | • | For State of Maryland / Departm 1 - State Registrar Certific | eate of Death | Reg. | 211118 | 05343 |
|------------|---|----------------|--|---|-------------------------------------|------------------------------|-------------------------------------|
| 3 | Dharinia | Ĉ, | 1. Decedent's Name (First, Middle, Last) | | Date of Death Month | Day Year | 3. Time of Death |
| | Physicia /Medic | | Mary Alice Jackson | | | 2008 | 7:20 A M |
| | Examin | ماجيع | 4a. Facility Name (If not institution, give street and number) 4b. (| City, Town, or Location of Death | | 4c. County of Death | |
| | S. | * | 7756 Finns Lane #B2 | Lanham | | rince Geo | rge's |
| | Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U Yrs. Mon | nder 1 Year If Under 24 Hrs. hths Days Hours Min. | 8. Date of Birth (Month, Day, Ye | | lace (State or Foreign try) |
| | Director | | 131-44-6148 55 | | Sept 19, | 1952 Vi | rginia |
| | and w | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | 11 | 0d. Inside City Limits |
| | sho sho | 'n | Maryland Prince George's Lanham | | | | 1 Yes 2 No |
| | the N | Director | | f. Zip Code | 100 | Citizen of What Coun | trv? |
| | with a or | | | | | | |
| | s 23 | Funeral | 77.56 Finns Lane #B2 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was D | 20706 | | Inited Sta | |
| | item item ner r | Ë | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 ♣ Married 11. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▶ No | ecedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto | Rican, etc.) | Black, White, | |
| 5 | rs aff | by F | If Yes, Give 1 🗆 Ye 3 Widowed 4 Divorced Year or Dates: | es 2 No Specify: | | Specify: Bla | ack |
| 3 | filed within 72 hours after death with the Maryland Hylgiene. Ither than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at | | 15. Decedent's Education 16a. Decedent's | Usual Occupation | 16b | . Kind of Business/Inc | dustry |
| 2 | in 72 n "ne fedic | Completed | (Specify only highest grade completed) (Give kind o | of work done during most of work OT use retired) | ting | | |
| 7 | with iene iene tha | E O | Elementary/Secondary (0-12) College (1-4or 5+) Facili | ty Services | G | overnment | |
| 3 | filed Hyg other | BeC | 17. Father's Name (First, Middle, Last) | 18. Mother's Nam | e (First, Middle, Maid | den Surname) | |
| 8 | s 1 and 2 should be filed within 72 hours after death with the Marylar of Heah and Mental Hygene. If Heam 23th and Mental Hygene. If Heam 21s marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | To B | Joseph Wynn | Alice | e Knight | | |
| | shound M | - | 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Add | dress (Street and Number or Rui | ral Route Number, Ci | ty or Town, State, Zip | Code) |
| Ĕ | and 2 ealth a n 27 is ier trau | | Alvin Wynn - Son 7756 Fi | nns Lane #B2 La | nham MD | 20706 | |
| ת ע | Hear Hear Hear Hear Hear Hear Hear Hear | | 20a Method of Disposition 20h. Place of Disposition | (Name of | | . Location - City or To | wn, State |
| 5 | | | 1 Burial 2 □ Cremation 3 □ Removal from State | ouglas | 10 0000 | а т | 7 1 3737 |
| = | artme ortan | | 1 TEMOLIAL I | ne and Address of Facility St | 12, 2008 | Staten Is | Inc. |
| 0 | permit. Page Department of Important: If any Injury or once. | | | 1 Benning Road | | | |
| | | | 23a Part 1 Inter the disease or complications that caused the death. Do not enter the | | · | | Approximate |
| | | | shock, or heart failure. List only one cause on each line. | | | | Interval Between Onset and Death |
| ا <u>ا</u> | Physician /Medical | | disease or condition resulting in death) | cardio rascu | lan Hec | un wise | ase- |
| | Examiner | | Due to (or as a consequence of): | | | | |
| | | <u>~</u> | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of): | | | | |
| | ted nsit | Examiner | cause. Enter Underlying Cause (Disease or injury | | | | |
| | xecu and | xar | that initiated events resulting in death) Last | | | | |
| 00/00 | ficate be executed g physician and as the burial-transit | | | | | | |
| 0 | ficate phys | edical | d | | | | |
| | certif ding se as | | IF FEMALE: 23c. If yes, outcome pf pregnancy | | | 23d. Date of delivery | |
| 200 | atter for u | Physician/M | In the past 12 months? | pic pregnancy er <i>(specify)</i> | | Month | Day Year |
| 5 | the d | ysi | 1 Yes 2 No 9 Unknown | | | | |
| Ľ | The law requires that the death certine law seem signed by the attending age 2 should be detached for use a | | Part II. Other significant conditions contributing to death but not resulting in the underly | ing cause given in Part I. | 23e. Did tobac | co use contribute to the | ne cause of death? |
| cords, | sign d be | d by | | | 1 ☐ Yes | 2 No 3 Prob | pably 4 Onknown |
| 5 | requiper / | Completed | | | 24a. Was an | 24h Ware outs | ppsy findings available |
| กั | e lav has je 2 s | ld m | | | autopsy performed | prior to co | mpletion of cause of |
| 5 | r Th | S | | | 1□ Yes 2 🔽 | | 2 No |
| N I G | ician certifi ector | Be | 25. Was case referred to medical examination of the second | Othor: | th (Check only one) | | |
| 5 | Phys this al dir | 10 | Tes 2 No 1 Inpatient 2 EH/Outpatient 3 | J DOA 4 Nursing H | ome 5 Residence 28d. Describe how i | e 6 Other (Special | <i>(y)</i> |
| | After uner | on: | 1 Natural 5 Pending (Month, Day Year) Injury | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe now i | njury occurred | |
| VISION | teath tor: the f | Certification: | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, fa | | 29f Looption /Ctroo | t and Number or Bur | al Pouto Number |
| \geq | or Ai fter o | Ħ | 4 ☐ Homicide determined building, etc. (Specify) | actory, office | City or Town, S | t and Number or Run tate) | ar noute Number, |
| _ | urs a | | 29a. Certifier 1 ☐ Certifying Physician : To the best of my knowledge, death occu | urred at the time, date and place | and due to the caus | ea(s) and manner as s | tated |
| | Hos 24 ho Fun etely 1 | edical | 29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, death occu | pation, in my opinion, death occu | rred at the time, date | and place, and due t | o the cause(s) |
| | To the Hospital or Attending Physician: The law within 24 butus after death. To the Funeral Director: After this certificate has completely filed in by the funeral director, page 2. | Med | 29b. Signature and title of certifier | 29c. License number | 29d. | Date signed (Month, | Day, Year) |
| | F 3 F 8 | _ | 1 1 2 and Alation | 4 | 517 F | 1.000 | 77 7 |
| 1 | (1) | | · Su vou / Just | 100357 | 100 | working | 1 4000 |
| 2 | (4) | | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Six Value 3 voy (to 2) talk | Drine Ch | nal | Manl | a -1 |
| | 0. | 40 | 31. Date filed (Month, Day, Year) 32. Registrar's Signafre | 3.7. | 1 | - Lugar | |
| | Sta | ite ar | EFR 1 1 2008 Keen 1 1 Average | | | | |

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Ye FEB 0 8 2008

| | | | For State Registrar | State | of Marylan | - | rtment of H | lealth and N Death | | jiene leg. No. 2 | 008 | 05345 | | |
|----------|--|----------------|--|--|--|------------------------|--------------------------|----------------------------------|---|---------------------|------------------------|--|--|--|
| ** | | | Decedent's Name (First, Middle) | , Last) | ? | | | | 2. Date of Dea | th | | 3. Time of Death | | |
| | Physicia | | Betty Jane | Kolar | | | | | Month Februar | Day 13. | Year 2008 | 12:05 a ^M | | |
| | /Medic Examin | married . | 4a. Facility Name (If not institution | | umber) | | 4b. City, Town, or | Location of Death | 1001001 | - | ty of Death | | | |
| | | Ž. | St. Mary's Hos | pital | | | Leonardt | :own | | St. M | fary's | | | |
| | Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In yrs. | last birthday) | | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day | 1 | | place (State or Foreign | | |
| | Director | | 346-14-9812 | 1□M 2X F | 85 | Yrs. | INCHAIG Bayo | Tiodio IVIIII | 12/23/1 | | | nois | | |
| | pu > | | Usual Residence of Decedent 10a, State 10b, County | | 10c Cit | y, Town or Lo | ation | | | | | 10d. Inside City Limits | | |
| | laryla shov sd at | 5 | , | | | • | | | | | | 1 X Yes 2 □ No | | |
| | the M | Director | Maryland St. Ma 10e. Street and Number | ry's | Leo | nardto | Vn 10f. Zip Code | | 1 | 10a. Citizen o | f What Cou | ntry? | | |
| ; | a or | | | | | | | | | | | , | | |
| | eath | Funeral | 22680 Cedar Lan | | ecedent Ever in U | .S. 13. V | 20650 Vas Decedent of H | ispanic Origin? (Sp | ecify Yes or No- | Inited 14. R | ace - Ameri | | | |
| | fter d r iten iner | ᇤ | 1 ☐ Never Married 2 ☐ Marri | ied 1 ☐ Yes | 2 🗶 No | 1 | f Yes, specify Cuba | an, Mexican, Puerto | Rićan, etc.) | | lack, White, | etc. | | |
| 000 | urs a al', o | þ | 3 XWidowed 4 ☐ Divorced | If Yes, (Year or | | 1 | I□Yes 2风No | Specify: | | Spec | | hite | | |
| 7 | 72 ho natur ical I | Completed | 15. Decedent | t's Education | 4) | | lent's Usual Occup | ation during most of work | kina | 16b. Kind of | Business/Ir | ndustry | | |
| <u> </u> | thin 'e. 'Med''r | ಠ | Elementary/Secondary (0-12) | - T | (1-4or 5+) | life. L | OO NOT use retired | i) | 9 | | | | | |
| 7 | ed wi ygien ier th t, the | ဦ ပြ | 12 | | *** | Publi | cation Ed | | (F) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | | tractor | | |
| and | be filed within 72 hours after death with the Maryland the Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Be | 17. Father's Name (First, Middle, | | | | | 18. Mother's Nam | | Maiden Surn | ame) | | | |
| <u>X</u> | ould Men narke | 은 | George Robert M | | | 1401 14 11 | | Selene T | | - C't T | - 0444- 7 | - 0-4-1 | | |
| <u>a</u> | 12 sh n and r is m raum | | 19a. Informant's Name/Relations | | | | , | and Number or Ru | | | | | | |
| ย์ | 1 and Healt Sm 2 | | Howard R. Austi 20a. Method of Disposition | n/Son | 20b. F | | Fielding sition (Name of | Road, H | OLLYWOOD Date | 20c. Location | 20636 n - City or T | | | |
| 5 | ages nt of . If its | | 1 ☐ Burial 2 X Cremation | | m State | cemetery, crer | natory or other plac | i i | | | | 11 10 | | |
| Daitimor | if. Partme | 4 | | A Donation 5 Other (Specify) Brinsfield-Echols Cre 02/14/2008 Charlotte Had Signature of Funeral Service Licensee Kyle S. Simons M01206 Brinsfield-Echols Cre 02/14/2008 Charlotte Had Signature of Facility Brinsfield Funeral Home 22955 Hollywood Road, Leonardtown, MD | | | | | | | | | | |
| 0 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | | Kyle S. Simo | Signature of Funeral Service Licensee Kyle S. Simons M01206 22. Name and Address of Facility Brinsfield Funeral Home, P. 22955 Hollywood Road, Leonardtown, MD 2065 Approxima shock, or heart failure. List only one cause on each line. Approximation of Funeral Home, P. Approximation of Funeral Service Licensee Brinsfield Funeral Home, P. Approximation of Funeral Home, P. Approximation of Funeral Service Licensee Approximation of Funeral Home, P. Approximation of Funeral Service Licensee Brinsfield Funeral Home, P. Approximation of Funeral Home, P. Approxima | | | | | | | | | | |
| F | | | 23a. Part1. Enter the disease, or shock, or heart failure. List | complications that | t caused the deat n each line. | th. Do not ent | er the mode of dyir | ng, such as cardiac | or respiratory ar | rest, | | Approximate Interval Between | | |
| F | Physician | 8 1 | Immediate Cause (Final disease or condition | mediate Cause (Final seaso or condition and a carrest due to malfunction of pacemaker | | | | | | | | | | |
| | /Medical | | Due to (or as a consequence of): | | | | | | | | | | | |
| | Examiner | | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | | | | | | | | | - | | |
| | sit s | Examine | cause. Enter Underlying Cause (Disease or injury that initiated events c. Sowce pulmon on hymertens, on | | | | | | | | | | | |
| | ecute and I-tran | хап | that initiated events resulting in death) Last | c. Due 1 | 17.17 | y | ny porten. | J, Un | | | - | | | |
| 8/60, | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit | | | | | | | | | | | | | |
| 200 | icate phys s the | dical | | | | | | | | | | | | |
| × | certif nding ise a | /Me | IF FEMALE: 23b. Was decedent pregnant | | 23d. I | 23d. Date of delivery | | | | | | | | |
| POX | death atter | cial | in the past 12 months? | ý | | | Month | Day Year | | | | | | |
| j | sician: The law requires that the di certificate has been signed by the rector, page 2 should be detached | Physician/M | 9 ☐ Unknown | 9□Uni | known | | | | | į | | | | |
| , , | s that ned b e deta | | Part II. Other significant condition | ons contributing to | death but not res | sulting in the u | nderlying cause giv | ren in Part I. | 23e. Did to | obacco use co | optribute to | the cause of death? | | |
| ĕ | quire en sig uld b | pe pe | Chronic rena | L Fa. lur | ٠. | | | | 1 🗆 \ | ′es 2∏ZNo | 3 □ Pro | bably 4 ☐Unknown | | |
| Hecords, | aw re | Completed by | | | | | | | 24a. Was | | b. Were aut | topsy findings available ompletion of cause of | | |
| r | The I | шо | | | | | | | perfo 1 Yes | rmed? | death? 1 ☐ Yes | 2 □ No | | |
| | ian: rtifica tor, p | a) | 25. Was case referred to medica | | | | 52.15 | 26. Place of Dea | | | | | | |
| _ | nyslc nis ce direc | To B | examiner? 1 ☐ Yes 2 Z No | Hospital: 1 | Inpatient 2 |] ER/Outpatier | nt 3□ DOA Oth | er: 4 ☐ Nursing H | ome 5□Resid | dence 6 □0 | Other (Spec | rify) | | |
| П 0Г | ng Pt fter th neral | | 27. Manner of Death 1 ☑ Natural 5 ☑ Pendin | | te of Injury onth, Day Year) | 28b. Time of Injury | f 28c. Injui Woi | ry at rk? | 28d. Describe I | now injury occ | curred | | | |
| 20 | tendi eath. or: A the fu | atic | 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could | gation | | | | Yes 2 □ No | | | | | | |
| DIVISION | or At fiter d Direct in by | Certification: | 4 Homicide determ | inad 200. Piz | ice of injury - At h ilding, etc. <i>(Speci</i> | ome, farm, str fy) | eet, factory, office | | 28f. Location (5 City or Tov | | mber or Ru | ral Route Number, | | |
| | pital ours a eral (| | 29a, Certifier 1 Certifyir | a Physician: To | the hest of my kno | owledge deat | h occurred at the ti | me, date and place | and due to the | cause(s) and | manner as | stated. | | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, | Medical | (Check only 2 Medical one) | Examiner: On the | | | 12 12 | and the second could be a second | 1 1 11 12 | Andrew Committee | and the second second | A- Ab | | |
| | To th Within To th | Me | 29b. Signature and title of certifie | 1 /// | / | | 29c. Licens | se number | | 29d. Date sig | ned (Month | n, Day, Year) | | |
| a | 0 | | > Memo | 11/1/1/4CL | - 60h | 73 | Do | 006047 | 3 | 02/1 | 3/20 | 08 | | |
| 1 | ton | | 30. Name and address of person | who completed ca | ause of death (Iter | m 23a) (Type, | Print) | se number 006047 | ord Rd | Mm | 211 | (25 | | |
| | | | St. Mary's Ho 31. Date filed (Month, Day, Year) | 30 | 25500 Begistrar's Sign | Leonov ature | o Tunn pe | In word | JUI 100. | 1.18/ | ~ 0 | -8 | | |
| | Sta Regist | | FFR 1 | | Same of the same o | K A | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 05346 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 5:58 A February 5, 2008 Louise С. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Calvert Prince Frederick If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🖾 F Yrs. 218-10-9666 04-14-1921 Maryland Director 86 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Medical Experies. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 No Director MD Calvert Chesapeake Beach 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3600 27th Street 20732 USA Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 2 💆 No f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: white 3 X Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marquess Cochrane 2 Lawrence 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Douglas King, son 3600 27th Street, Chesapeake Beach, MD 20732 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Harmony Cemetery 02-08-2008 Owings, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. Illian 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage Renal Disease Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by to d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Carcinoma Left Lung, Coronary Artery Disease 1 🗌 Yes 2X No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Diabetes Mellitus II, Hypertension 24a Was an autopsy performed? res 2 X No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural Injury

aw requires that the death certificate be executed Box 68760, P.0. Division or Vital Records, Hospital or Attending death.

Baltimore, Maryland 21215-0036

To the Funeral Director: After the completely filled in by the funeral Certification: To the Hospital within 24 hours a To the Funeral I

5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

29b. Signature and title of certifie

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

> D-25435 02-05-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

110 Hospital Road, Suite 305, Prince Frederick, MD 20678 Mukesh Mathur, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signatu

State Registrar

Medical

| | | | 1 - For State Registrar | State of Marylar | nd / Depa <i>Cei</i> | artmen rtificat | t of He | ealth and Death | Mental Hy | /giene Reg. No | prime and and | 18 | 05347 | |
|---|--|----------------|---|---|-------------------------------------|-------------------------------------|-----------------------------|--|--|----------------------|-----------------------------------|-------------------------------------|--|--|
| | Physici | an | Decedent's Name (First, Middle, Last) | | | | | | 2. Date of D Month | eath Da | y Y | 'ear | 3. Time of Death | |
| | /Media | | | niskern | | | | | Februa | rsz / | 200 | 8 | 3:11p M | |
| | Examir | ner | 4a. Facility Name (If not institution, give s | , | | | | _ocation of Dea | th | 4c. | . County of | | | |
| | F | | Holy Cross Hospit 5. Social Security Number 6. Sex | | last birthday) | If Under | | Spring If Under 24 Hrs | 8 Date of B | dh | | | omery ace (State or Foreign | |
| | Funeral Director | | | M 2□F 67 | Yrs. | Months | | Hours Min | | | | Coun | try) | |
| | ט | | Usuaf Residence of Decedent | | | | | | TED. C | , 13 | 40 | Mem | York | |
| | how | | 10a. State 10b. County | 10c. Ci | ty, Town or Lo | cation | | | | | | 10 | Od. Inside City Limits | |
| | Be-f | Director | Maryland | Montgomery | | Silve | r Spi | ring | | | | | 1 ☐ Yes 2 ☑ No | |
| | death with the Maryland ms 23a or 28e-f ehow rmust be notified at | | 10e. Street and Number 14443 Pebblestor | ne Drive | | 10f. Zip | | 905 | | - | izen of Wha | at Coun | try? | |
| 30 | d within 72 hours after death with the Marylan jiene. r then "natural", or items 23a or 28e-1 ehow the Madical Examiner must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 2√2 Married 3 □ Widowed 4 □ Divorced | 2. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: | | Was Deced f Yes, spec 1 ☐ Yes | | panic Origin? (\$, Mexican, Puer Specify: | Specify Yes or N to Rican, etc.) | 0- | 14. Race - Black, Specify*W | White, e | etc. | |
| 3 | tural | | 15. Decedent's Educ | | 16a. Deced | ient's Usu: | al Occupat | ion | | 16h K | ind of Busin | | | |
| <u>.</u> | n "nat | Completed | (Specify only highest grade | completed) | (Give | kind of wo | rk done du | iring most of wo | nrking | 100.10 | ind or busin | 1033/1110 | ustry | |
| 7 | d within giene. rr then " | E | Elementary/Secondary (0-12) | College (1-4or 5+) 4 | Meteor | roloa | ist/C | ceanogi | ranher | II. S | GOV | ornm | ent/NOAA | |
| 2 | be filed tral Hygid of other event, I | BeC | 17. Father's Name (First, Middle, Last) | | 110000 | corog | | | me (First, Middle | | | CLIII | IEITC/ NOAA | |
| <u>a</u> | should b nd Menta r marked umatic e | To | Jason R. Kniskerr | 1 | | | | Sylva | Mae R | unk1 | e | | | |
| a L | and lam | 1 | 19a. Informant's Name/Relationship (Тур | | 19b. Mailir | g Address | (Street ar | nd Number or R | ural Route Numi | er, City o | or Town, St | ate, Zip | Code) | |
| ≥ | es 1 and 2 should be filed of Health and Mental Hygis fitem 27 is marked other r other traumatic event, II | | Julia Ann Kniskern | | 1 | | | one Dri | lve, Sil | ver | Sprin | g, M | ID 20905 | |
| e e | Pages 1 nent of H int: If Iter iny or oth | 1 3 | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re | , | Place of Dispo cemetery, cren | sition (Nar natory or o | me of other place, | Fe | Date b. 5, | 20c. Lo | ocation - Ci | ty or To | wn, State | |
| Ē | ment tant: | | 4 □ Donation 5 □ Other (Specify) | Me | tropol | itan | Crema | tory 2 | 2008 | Alex | andri | a, V | 'irginia | |
| ğ | permit. Pages 1 an Department of Heal Important: If Item 2 ony injury or other once. | | 21. Signature of Funeral Service Ligense | Donation 5 Other (Specify) Metropolitan Crematory 2008 Alexandria, 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Sprin | | | | | | | | | | |
| | uu z v u | | 147 2634 | 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, let Cause (Final) | | | | | | | | | | |
| /Medic Examin | Physician /Medical Examiner | Examiner | shock, or hear failure. List only one cause on each line. | | | | | | | | | Interval Between Onset and Death | | |
| 000 | te be ey ysician ye buria | cal | Due to (or as a consequence of): d. | | | | | | | | | | | |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the burial-transit | the death certifica by the attending ph eched for use as th | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | | | | | | | | | | ry Day Year | |
| ٦, ر | res that signed to be det | Ď | Part II. Other significant conditions conf | | - | | | in Part I. | | | | | e cause of death? | |
| 5 | nead | etec | Alzheimer's Diseas | e | | | | | - | | | | ably 4 ⊠Unknown | |
| בו | The law ate has t page 2 s | Completed | | | | | | | 24a. Was auto perf 1 Yes | psy ormed? | prio | re autop or to com th? Yes | osy findings available inpletion of cause of | |
| | Iclen Sertific Botor, | Be | 25. Was case referred to medical examiner? | | | | | | ath Check only | one) | | | | |
| 5 | Physi this c | 2 | TET TES ZIXINO | | ER/Outpatien | | | 4 🗆 Null Sing r | lome 5 ☐ Res | | | (Specify |) | |
| | ling f | 0 | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of fnjury (Month, Day Year) | 28b. Time of fn _f ury | 1 | 8c. Injury a Work? | | 28d. Describe | how injur | y occurred | | | |
| 2 | death death stor: | cat | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be | 29a Place of Injury At h | | M | | s 2 No | Opt Leasting | /C+ | - 1 A I | | | |
| 2 | s after s after al Direc ed in by | Certification: | 4 Homicide determined | 28e. Place of Injury - At he building, etc. (Specif | y) | eet, ractory | /, опісе | | City or To | | | or Hurai | Route Number, | |
| | n 24 hour n 24 hour ne Funer stely fills | Medical (| 29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin | cian: To the best of my kno er: On the basis of examina and manner stated. | wtedge, death tion and/or inv | occurred restigation, | at the time , in my opir | , date and place nion, death occi | e, and due to the urred at the time | cause(s) date and | and mann d place, and | er as sta due to | ated. the cause(s) | |
| | Vithi Vithi Comp | Σ | 29b. Signature and title of certifier | 0 | | 290 | . License | number | | 29d. Da | te signed (/ | Month, E | Day, Year) | |
| 1 | - | | 10xle A | Cherry. | MC | | D26 | 520 | | Foh- | uary | 6 | 2008 | |
| /- | - | | 30. Name and address of person who cor | | | | _ | | | | | U, | 2000 | |
| | | | Phyllis Schreiner, | | | e Bly | vd., | Rockvil | le, MD 2 | 20852 | 2 | | | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | 32. Registrar's Signa | ture do | wie | | | | | | | | |

| | | | riogiotiai | ertificate of | Death | | giene Reg. No. 2008 | 3 05348 |
|---------------------|---|------------------|---|---|---|------------------------|--|--|
| | Physicia | an | 1. Decedent's Name (First, Middle, Last) David Erwin Kaj | oalko, S | r. | 2. Date of Dea | Day Year | 3. Time of Death |
| | /Medic | en i | 4a. Facility Name (If not institution, give street and number) | 4h City Town o | or Location of Death | 00 | 4c. County of Dea | |
| 6 | Examin | er | 13015 Weiss Drive | Bowie | 2 Location of Doath | | Prince (| |
| | Funeral | | Social Security Number 6. Sex 7. Age (In yrs. last birthday) | If Under 1 Year | | 8. Date of Birt | h 9 Bi | rthplace (State or Foreign |
| ľ | Director | | 296–62–6862 110 M 2□F 49 Yrs. | Months Days | Hours Min. | (Month, Day Dec. 30 | | ountry) |
| | ם , | | Usual Residence of Decedent | acetion | | | | 10d. Inside City Limits |
| | arylaı show d at | - | 10a. State 10b. County 10c. City, Town or I 10c. City, Town | | | | | 1 ☐ Yes 2 No |
| | the M 28a-f otifie | ectc | 10e. Street and Number | 10f. Zip Code | | | 10g. Citizen of What C | |
| | with a or the n | Funeral Director | 13015 Weiss Drive | 20715 | | | USA | , |
| | ns 23 | era | | | Hispanic Origin? (Spe oan, Mexican, Puerto | cify Yes or No | | |
| 36 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Fur | 1 Never Married 2 Married 1 Yes 2 No If Yes, Give | 1 ☐ Yes 2 ☐ No | | Hican, etc.) | | nite |
| Ö | hours tural' al Ex | q pa | | edent's Usual Occu | pation | | 16b. Kind of Business | s/Industry |
| <u>γ</u> | in 72 n "na fedic | plet | (Specify only highest grade completed) (Giv | e kind of work done DO NOT use retire | during most of worki d) | ng | U.S. Arm | , |
| 72 | yiene. r thar the N | Completed | Elementary/Secondary (0-12) College (1-4or 5+) 5+ | Col.U.S.A | rmy | | O.B. AIM | У |
| Maryland 21215-0036 | e filed al Hyg I othe vent, | Be C | 17. Father's Name (First, Middle, Last) | | | | Maiden Surname) | |
| <u> a</u> | Ment Ment arked aric e | LO L | Erwin Kapalko | | | eth Bel | | |
| lar | 2 sho | | , , , | • | | | er, City or Town, State, | Zip Code) |
| | 1 and lealth | 8 | | | Dr. Bowie | MD 207 | 20c. Location - City o | r Town. State |
| altimore, | ages nt of h | | | position (Name of ematory or other pla | , 1 (1) | 14, | Avon, Ohio | , rown, otato |
| == | artmel artmel ortant Injury | | 4 Donaties 5 Other (Specify) St. Josep 21. Signatule of Funeral Service Disease | Dh'S Cem. 22. Name and Addre | ess of Facility | 0 | | |
| Ba | permi Depa Impo any Ir | | 222 | neral Home MD 20715 | | | | |
| rij. | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. | ing, such as cardiac o | or respiratory a | rrest, | Approximate Interval Between Onset and Death | |
| | Physician | | Immediate Cause (Final disease or condition as SARCOM | | | | 44 Jan | |
| | /Medical Examiner | | Due to (or as a consequence of): | | | | | , |
| 12 | \$\frac{\xi_{\text{Pol}}^{2,0}}{2\text{pol}} = \frac{\xi_{\text{Pol}}^{2,0}}{2\text{pol}} | - | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of): | | | | | |
| | uted J ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or lings) that initiated events | | | | | |
| oʻ | exec an and rial-tra | Exa | resulting in death) Last C. Due to (or as a consequence of): | | | | | |
| 8760, | Attending Physician: The law requires that the death certificate be executed r death. r death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit | lical | d | | | | | |
| Box 6 | ertifica ding ph | Physician/Med | IF FEMALE: 23c. If yes, outcome pf pregnancy | | | | 001 B-111 | |
| Bo | w requires that the death certific been signed by the attending p should be detached for use as | cian | in the past 12 months? | Month | 23d. Date of delivery Month Day Year | | | |
| o. | the d | ysid | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | Other (specify) _ | | | | |
| Records, P.O. | s that ned b | by Pr | Part II. Other significant conditions contributing to death but not resulting in the | underlying cause gi | ven in Part I. | 23e. Did t | obacco use contribute | to the cause of death? |
| ğ | quire; in sig uld be | q pe | | | | 1 🗆 ' | Yes 211 No 3□1 | Probably 4 □Unknown |
| 000 | aw re Is bee 2 sho | Completed | | | | 24a. Was | an 24b. Were | autopsy findings available completion of cause of |
| <u> </u> | The ate ha | No. | | | | perfo 1∐ Yes | ormed death? | ? |
| <u>Ita</u> | ertific ctor, | Be (| 25. Was case referred to medical examiner? | la. | 26. Place of Deatl | (Check only o | one) | |
| 7 | hysion this o | 우 | 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati | elli all pox | | | dence 6 □Other (Sp | pecify) |
| U C | ling F | ion: | 27. Manner of Death Autural 5 Pending (Month, Day Year) Injury 28b. Time (Month, Day Year) | / Wo | iry at ork?]Yes 2 □ No | 280. Describe | how injury occurred | |
| Division or Vital | Attende death ctor: | ficat | 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, | | | 28f. Location (| Street and Number or i | Rural Route Number, |
| <u>S</u> | r de in | Certification: | 4 Homicide determined building, etc. (Specify) | | | City or To | wn, State) | |
| | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. | | 29a. Certifler (Check only Medical Examiner: On the basis of examination and/or | | | | | |
| | the hin 24 the F the F | Medical | one) and many ar stated. | | se number | 1 | | |
| | 70 Viti | 2 | 29b. Signature and title of certifier | | | | 29d. Date signed (Mo | |
| • | (| | M M M M M M M M M M M M M M M M M M M | D Print) | 1730 | | 1 en mi | 1,01,2000 |
| R | (3) | | 30 Namer and address of person why completed cause of death (Item 23a) (Typ MICHAEL LA ENA W. 441 31 Date filled (Month Day, Year) 32 Registrar's Signature | DEFENSE | + HIGHL | NAY A | NOVAPOLIS 1 | MD21401 |
| | Sta | te | or. Bate filed (Internity, Bay, Tear) | | | , ¢ | | |
| | Registr | ar | FEB 1 1 2008 Keen & April | * | | | | |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene
Amend Items 25,27,28a-f per me 4876 02/21/08dhb

Red, No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician GRIGORIY KARCHEMNIK JANUARY 25, 11:44 Α 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ROCKVILLE SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 X M 2 ☐ F MARCH 6, 1935 RUSSIA Director 72 214-55-4429 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MARYLAND MONTGOMERY DERWOOD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A 16116 CRABBS BRANCH WAY #14 20855 death \ by Funeral Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or iten ury or other traumatic event, the Medical Examinear ury or other traumatic event, the Medical Examinear. 1 Never Married 2 N Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ MECHANICAL ENGINEER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ AYZIK KARCHMNIK FAINA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:4 Department of Health at Important: If Item 27 Is any injury or other trau NELLYA G. URES/WIFE 16116 CRABBS BRANCH WAY #14, DERWOOD, MARYLAND 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 Removal from State 4 Donation 5 Dother (Specify) JUDEAN MEMORIAL GARDENS 01/27/2008 OLNEY, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME, INC. 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 23a. Part1. Enter the disease, or combileations that caused the dead. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIAC ARRYTHMIA /Medical Due to (or as a consequence of): Examiner RESPIRATORY FAILURE CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed INTRACEREBRAL HEMORRHAGE burial-trar Due to (or as a consequence of): Box 68760 physician Physician/Medical SUBDURAL HEMATOMA the as IF FEMALE: nse s 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year for Day 4□Pregnant at time of death 5 Other (specify) P.0. ned by the a e detached f 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by sign I be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan CHRONIC KIDNEY DISEASE s certificate has b lirector, page 2 s autopsy 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 X 1 Yes 21X1 No မှ this 28a. Date of Injury 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury T ∰Natural 5 ☐ Pending investigation Subject fell. 1 Tyes 2K Accident 01/21/2008 Unknowii M within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number of Rural Route Numb City of Town, State) 16116 Crabbs Branch Way #14, Derwood, MD determined 4 ☐ Homicide Home To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0064478 JANUARY 26, 2008 30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print) FISEHATSION, MEHARI, M.D. 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND 20850 egistrar's Signature 31. Date filed (Month, Day, Year) State JAN 28 PARIAL S 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 7, 2008 **Physician** Priscilla Catherine Loud 8:10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Solomons Nursing Center Calvert Solomons If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 84 September 14,1923 005-20-4111 Maine Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Calvert Solomons 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number within 72 hours after death with 13325 Dowell Road 'naturai", or items 23a 20688 United States Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical Elementary/Secondary (0-12) College (1-4or 5+) D.C. Government 12 Social Worker is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and important: If item 27 is many injury or other traum Dolly Record / Friend 13439 Allnutt Lane, Highland, MD 20777 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 02/08/2008 Alexandria, VA Metropolitan Cremetory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4405 Broomes Island Rd., Port Republic, MD 20676 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final obstructive 5 years Physician hromic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dies to (or as a consequence of) Examine The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

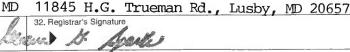
the Hospital or Attending Physician: 24 hours after death Funeral Director: within 24

State Registrar

Charles Bennett, MD 31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and title of certifier



and manner stated.

Dennett M. O

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

25156

29d. Date signed (Month, Day, Year)

February 8, 2008

| | | | For State Registrar | State of Mary | • | artment of H | | Mental Hygien | -21Hi2 | 05351 | |
|---|--|------------------|--|---|---|--|--|---|-------------------------------------|--|--|
| 7 | Physicia /Medic | | Decedent's Name (First, Middle ADE | | EIFE | R | | 2. Date of Death Month | 07 2008 | 3. Time of Death 6.30 AM | |
| | Examin | 5 0 Z db | 4a. Facility Name (If not institution Hebrew Home of | - | ington | 4b. City, Town, or Rockv | Location of Death | h 4 | lc. County of Dea Montgome | th | |
| | Funeral Director | | 5. Social Security Number 252-03-8000 | 6. Sex 7. Age (/ | n yrs. last birthday) 92 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | (Month, Day, Yea | 916 Geo | thplace (State or Foreign ountry) orgia | |
| ryland | how | | Usual Residence of Decedent 10a. State 10b. County | 11 | 0c. City, Town or Lo | cation | | | | 10d. Inside City Limits 1 ☐ Yes 2 📉 No | |
| h the Ma | r 28a-f s notified | Funeral Director | Maryland Montg 10e. Street and Number | omery | Rockvi | 10f. Zip Code | | | Citizen of What Co | ountry? | |
| ath wit | 23a o ust be | ralD | 11410 Strand D | | | 2085 | | | nited St | | |
| irs after de | al", or Items xaminer m | by | 11. Marital Status 1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced | 12. Was Decedent Eve Armed Forces? ied 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: | 1 | Was Decedent of H If Yes, specity Cuba 1 □ Yes 2【X] No | lispanic Origin? (S an, Mexican, Puer Specify: | pecity Yes of No- to Rican, etc.) | Black, Whi | | |
| should be filed within 72 hours after death with the Maryland | ne. han "natura e Medical E | Completed | 15. Decedent (Specify only highest Elementary/Secondary (0-12) | College (1-4or 5+) | (Give | dent's Usual Occup kind of work done DO NOT use retired | during most of wo | | Kind of Business | | |
| i Malij | Hygier ther the | Co | 17. Father's Name (First, Middle, | 4 Last) | Home | maker | 18. Mother's Na | me (First, Middle, Maid | | | |
| la h | Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | To Be | Harry Kuni | ansky | | | | line Rosent | | | |
| , INIGII | | | 19a. Informant's Name/Relations Sarietta Kaye, | Daughter | 11410 | d Drive #309, Rockville, MD 20852 of Date: Date | | | | | |
| Pages 1 and 2 | | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S | | 20b. Place of Dispo cemetery, cre Arlingtor | | , , | Arlingto | | | |
| Dall | | | 21. Signature of Funeral Service | Licensee | T ² 0 | 2. Name and Addre Drchinsky 34. Carrol | ss of Facility Hebrew 1 S+ N | Funeral Hom W, Washingt | ne ton. DC | 20012 | |
| | | | | only one cause on each line. | e death. Do not en | ter the mode of dyir | ng, such as cardia | c or respiratory arrest, | | Approximate Interval Between Onset and Death | |
| | hysician /Medical | | Immediate Cause (Final disease or condition resulting in death) | Due to (or as a c | ROVA50 consequence of): | MELL | OCCI V | 6101 | | | |
| E | kaminer | e | Sequentially list conditions, if any, leading to immediate | | | | | | | | |
| bourted | and I-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | |
| o vou. | physician and the burial-transit | dical E | | | | | | | | | |
| The law requires that the death cartific | certificate has been signed by the attending placetor, page 2 should be detached for use as t | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | | 23d. Date of de Month | elivery Day Year | | | | | |
| COLOS, P. | n signed by | þ | Part II. Other significant condition | ons contributing to death but | not resulting in the u | inderlying cause giv | ven in Part I. | 23e. Did tobacc | | to the cause of death? Probably 4 Wunknown | |
| | ate has bee page 2 sho | Completed | | | | | | 24a. Was an autopsy performed 1∐ Yes 2 ☑ | l prior to | autopsy findings available completion of cause of | |
| Or VICAL | certific rector, | Be | 25. Was case referred to medica examiner? | Hospital: | 0 □ ED/Outpatio | nt 3CLDOA Ott | ner: \ | eath (Check only one) | | | |
| VISION OF | ral di | tion: To | 1 Yes 2 No 27. Many r of Death 1 Natural 5 Pendir 2 Accident investi | 28a. Date of Injury (Month, Day) | 28b. Time o | of 28c. Inju | 4 Nursing | Home 5 Residence 28d. Describe how in | | есіту) | |
| 5 8 | after dear I Director d in by the | Certification: | 3 Suicide 6 Could 4 Homicide determ | | / - At home, farm, st (Specify) | reet, factory, office | | 28f. Location (Stree City or Town, S | t and Number or I tate) | Rural Route Number, | |
|] | 24 hours le Funera | edical C | 29a. Certifier 1 Certifyla (Check only one) 2 Medical | ng Physician: To the best of Examiner: On the basis of e and manuerstate | examination and/or in | th occurred at the t nvestigation, in my | ime, date and plac opinion, death oc | ce, and due to the caus curred at the time, date | e(s) and manner and place, and d | as stated. ue to the cause(s) | |
| T. | Withir comp | Me | 29b. Signature and title of certific | u Kall | rug He | D 29c. Licent | se number 3543 | 5 FG1 | Date signed (Moi | nth, Day, Year) | |
| , |) | i | 30 Name and address of person | who completed pause of dea | / (Item 23a) (Type | Went Re | SEROHI | D, ROCK VI | 1115,1 | 4 D1, 200P 4 D 2085Z | |
| 1 1 | Sta Regist | ate rar | 31. Date filed (Month, Day, Year) | 7 2008 32. Registrar | 's Signature | perte | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** Patricia E. Luciani P^{M} 2:54 February 4, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. Cify, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day) Jan. 21 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Montana Director <u>519-34-3557</u> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ms 23a or 28a-f show must be notified at 1 ☐ Yes 2X No Director MD Prince George's Bowie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2706 Keystone Lane USA 20715 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Examiner ☐Yes 2☑ No Yes, Give 1 Never Married 2X Married 1 ☐ Yes 2X No þ Specify 3 Widowed 4 Divorced "natural", Year or Dates White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 7 is marked other than "natu traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Restaurants Management 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Spence Wilbur Farnham မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau 20715 Pasquale Luciani/Husband 2706 Keystone Lane Bowie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 DBurial 2 □ Cremation 3 □ Removal from State Lakemont Mem. Gards. 2/8/2008 4 ☐ Donation 5 ☐ Other (Specify) Davidsonville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenser Beall Funeral Home Bowie, <u>6512 NW Crain Hwy.</u> 23a. Part. Enter the disease, or complications that caused the death shock, or heart failure. List only one cau, on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine y physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical as IF FEMALE nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Month 5 Other (specify) ed by the a detached f 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate ha autopsy performed death? 1 ☐ Yes 21 No 1∐ Yes 2 1 No director 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this (28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760. Division or Vital Records,

altimore, Maryland 21215-0036

Hospital or Attending Physician: hours after death. 24 hours a

by

filled

completely within 24 State

MO 30. Name and address

29c. License number

1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

f person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

29b. Signature and title of centre

4 Homicide

(Check only one)

29a. Certifier

2008 FEB 11



Registrar

| | | | 1 - For State Registrar | State of Mar | | artment of Heartificate of De | | ntal Hygie | 2000 | 05353 |
|--|---|------------------|--|---|---------------------------------------|---|-------------------------------|-----------------------------|-------------------------|--|
| | Dhusiai | | 1. Decedent's Name (First, Middle | , Last) | | | 2. | Date of Death Month | Day Year | 3. Time of Death |
| | Physici /Medio | _ | ANN LESLI | | rtig | | | | 6, 2008 | 8:15 A M |
| 7 | Examir | er | 4a. Facility Name (If not institution | | | 4b. City, Town, or Lo | ocation of Death | | 4c. County of Death | |
| | | | 106 Somers Cove | | (In yrs. last birthday) | | sfield fUnder 24 Hrs. 8 | Date of Birth | Somer 9. Birth | |
| | Funeral Director | | 220-34-4869 | 1□M 2X F | 71 Yrs. | | Hours Min. | (Month, Day, Ye | 6, 1936 Mary | place (State or Foreign ntry) 7] and |
| | D | | Usual Residence of Decedent | | | | | | | |
| | arylar show | _ | 10a. State 10b. County | | 10c. City, Town or Lo | | | | | 10d. Inside City Limits 1 X Yes 2 No |
| | 8a-f | cto | Maryland Somer | set | | Crisfi | ield | 40- | . Citizen of What Cou | |
| | with the | 吉 | 10e. Street and Number | | | 10f. Zip Code | | log. | | intry : |
| | eath | eral | 106 Somers Cove | Apartments 12. Was Decedent Ev | ver in U.S. 13. | Was Decedent of Hisp | 1817 Janic Origin? (Specif | v Yes or No- | USA 14. Race - Ameri | ican Indian, |
| " | r Item | Funeral Director | 1 XNever Married 2 Marri | Armed Forces? ed 1 ☐ Yes 2 🗓 No | | Was Decedent of Hispa If Yes, specify Cuban, | | éan, etc.) | Black, White | _ |
| 036 | 72 hours after death with the Maryland natural', or Items 23e or 28a-f show Jical Exercified at | þ | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: | | 1 □ Yes 2 🗓 No | Specify: | | Specify: Wh | ıte |
| 21215-0036 | 72 hc | Completed | 15. Decedent (Specify only highes | 's Education t grade completed) | (Give | dent's Usual Occupation kind of work done duri | on ring most of working | 168 | b. Kind of Business/Ir | ndustry |
| 121 | within ene. then * | ם | Elementary/Secondary (0-12) | College (1-4or 5+ |) | DO NOT use retired) | | | Hognit-1 | |
| 2 | Hygie Hygie ther t | | 12 17. Father's Name (First, Middle, | Last) | 500 | cial Worker | 8. Mother's Name (F | | Hospital iden Sumame) | |
| lan | ld be ental ked o | To Be | Edgar Leslie La | | | l F | Flora Beat | rice Jo | nas | |
| Maryland | s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. item 27 Is marked other then "natural", or Items 23e or 28a-f show other treumatic event, If a Machel Exertir or must be notified at | - | 19a. Informant's Name/Relations | | 19b. Maili | ng Address (Street and | | | | p Code) |
| | is 1 and 2 of Health a item 27 ls | | Harry Langlutti | g (Brother) | | 4 Wheaton | Way - Ell | | | |
| altimore, | ges 1 t of He If iten or oth | | 20a. Method of Disposition 1 ☐ Burial 2 🖔 Cremation | 3 ☐Removal from State | 20b. Place of Dispo cemetery, cres | nsition (Name of matory or other place) | Date | 200 | c. Location - City or T | own, State |
| Ë | Pag Iment tant: jury c | | ' 4 ☐ Donation 5 ☐ Other (S | pecify) | | 7 Crematory | | | | |
| Ball | permit. Pages. Department of H Important: If ite any injury or ot once. | | | radshaw-Pruit | it 3 | 2. Name and Address of BO6 W. Main | Street - | - Crisfi | eld, MD 2 | 1817 |
| | | | 23a. Part1. Enter the disease, or shock, or heart failure. List | complications that caused the complications that cause on each line | he death. Do not en | ter the mode of dying, | such as cardiac or r | espiratory arrest | , | Approximate Interval Between Onset and Death |
| | Prysician | i 10 | Immediate Cause (Final disease or condition resulting in death) | a. Còn | ouc'Anrob | | | | | |
| | /Medical Examiner | | | Due to (or as a | consequence of): | u Su moron | e | | | |
| | | er | Sequentially list conditions, if any leading to immediate | b. Due to or as a | consequence of): | ng Syndron sperteneson | į. | | | |
| | uted | Examin | cause. Enter Underlying Cause (Disease or injury that initiated events | Me | lignary Hi | spert sucron | U | | | |
| o, | be executed sician and burial-transit | Ex | resulting in death) Last | Due to (or as a | consequence of): | 7 | | | | |
| 8760, | ate be ex hysician the buria | dlcal | | d | | | | | | |
| 9 | The law requires that the death centificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit | /Mec | IF FEMALE: | 23c. If yes, outcome of | foregnancy | | | | 23d. Date of deliv | 10.01 |
| Вох | atten for us | Physician/Me | 23b. Was decedent pregnant in the past 12 months? | 1 Live birth 2 | Fetal death 3 | Ectopic pregnancy Other (specify) | | | Month | Day Year |
| o. | that the de ed by the detached | ıyslı | 1 □ Yes 2 ☎No 9 □ Unknown | 9□ Unknown | | | | | | |
| Q | res that igned b | by Pł | Part II. Other significant condition | | not resulting in the u | inderlying cause given | in Part I. | 23e. Did tobac | cco use contribute to | the cause of death? |
| rds | w require been sig should b | ed b | Dra | Sefin Mallitus | | | | 1 🗆 Yes | 2 No 3/2 Pro | bably 4 Unknown |
| Records, | e law requ has been je 2 shoul | Completed | | | | | | 24a. Was an autopsy | prior to c | opsy findings available ompletion of cause of |
| <u>m</u> | The ate h page | Con | | | | | | performe 1 ☐ Yes 2 【 | do death? No 1 ☐ Yes | 2 🗆 No |
| Vital | ding Physician: The In. After this certificate hat funeral director, page | Be | 25. Was case referred to medical examiner? | Hamitali | | | 26. Place of Death (| 4 | - | |
| of | Physical direction | 2 | 1 Yes 2 No 27. Manner of Death | Hospital: 1 Inpatient | | | 4 Liversing Floring | 5 Residence d. Describe how | be 6 Other (Specialized | ify) |
| O | ding P. h. After funer | tlon | 1 ☑Natural 5 ☐ Pendin | | Year) Injury | Work? | | | ,, | |
| 29a. Certifier | | | | | | | | | ral Route Number, | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| MGM mD 10015715 02/06/2008. | | | | | | | | 2008 | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Gill, M.D 26423 Burton Avenue - Crisfield, Maryland 21817 | | | | | | | | | | |
| | Sta Regist | | 31. Date filed (Month, Day, Year) | 8 2008 32. Registrar | 's Signature | · | | | | |

DHMH 17 Rev 1/2001

ORIGINAL

1/31/2008

Preston MD 21655

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Melinde Butter

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

136

Are

MD

Lednum

D0053255

| | | | For State of Marylai | | artment of F | | , | 000 | 0 00000 | | |
|----------|--|----------------|--|----------------------------------|--|---|---|---|--|--|--|
| | | Ã. | Registrar 1. Decedent's Name (First, Middle, Last) | - 001 | i lilicale oi i | Dealli | 2. Date of Dea | Reg. No. | 3. Time of Death | | |
| | Physici | | Mary Florence Mason | | | | Month | Day Year | M | | |
| | /Medic | | 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, o | Location of Deat | | 4c. County of Dea | | | |
| | | | St. Mary's Nursing Center | | Leonardt | own | | St. Mary | 7 S | | |
| | Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs 1 1 M 2 M F 87 | s. last birthday) 7 Yrs. | If Under 1 Year Months Days | If Under 24 Hrs. Hours Min. | 8. Date of Birti (Month, Day 11/16/ | y, Year) 9. Bi | rthplace (State or Foreign ountry) yland | | |
| | w w | | Usual Residence of Decedent 10a. State 10b. County 10c. C | ity, Town or Lo | ocation | | | | 10d. Inside City Limits | | |
| | Maryl f sho ied al | Į. | Maryland St. Mary's Lex | ington | Doule | | | | 1 □Yes 2 No | | |
| | r 28a | Director | 10e. Street and Number | THELOH | 10f. Zip Code | | | 10g. Citizen of What C | ountry? | | |
| | th wit 23a o 1st be | a D | 21688 Ranger Road | | 20653 | | τ | Jnited Stat | es | | |
| ٥ | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Ifem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | Funeral | 11. Marital Status 12. Was Decedent Ever in U Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U Armed Forces? | | Was Decedent of H | an, Mexican, Puer | pecify Yes or No- to Rican, etc.) | Black, Wh | | | |
| 2-002p | thours atural", cal Exan | ed by | 3 X Widowed 4 □ Divorced If Yes, Give Year or Dates: | 16a. Dece | 1 ☐ Yes 2 🛣 No dent's Usual Occup | Specify: ation | | Specify: B 16b. Kind of Business | lack //ndustry | | |
| 2 2 | within 72 ene. than "na he Medi | Completed | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 | (Give | kind of work done of DO NOT use retired | during most of wo | rking | | , | | |
| ם ע | filed Hygid Sther ent, tl | | 17. Father's Name (First, Middle, Last) | пошеш | akei | 18. Mother's Nar | me (First, Middle, | Own Home Maiden Surname) | | | |
| <u>a</u> | ould be filed Mental Hyg arked other atic event, i | To Be | James Ignatius Hebb, Sr. | | | Mary Flo | rine Tui | ner | | | |
| ary | 2 shour and N is mai | - | 19a. Informant's Name/Relationship (Type. Print) | 19b. Mailir | ng Address (Street | | | r, City or Town, State, | Zip Code) | | |
| , Ma | t and 2 Health a tem 27 is | | Mary M. Jones/Daughter | | Louisdal | | | | 0619 | | |
| o ce | Pages 1 nent of H ant; If iter ury or oth | | 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State | Place of Dispo cemetery, crei | osition (Name of matory or other plac | ce) | Date | 20c. Location - City o | r Town, State | | |
| Daiminor | t. Pag tmen tant: ijury | | 4 □ Donation 5 □ Other (Specify) | naculat | e_Heart (| | | exington I | | | |
| מ | permit. Pages Department of Important: If it any Injury or o | | 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 | 2 | 2. Name and Addres 2955 Ho11 | ywood Ro | ad, Leor | l Funeral H nardtown, M | - | | |
| | | | 23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. | | | | | rest, | Approximate Interval Between | | |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a conse | tc P | MAY THI ALTERI | 4/4 | | | Onset and Death | | |
| | Examiner | | Due to (or as a conse | quence on: VARY | ALTERY | DIEA | ST | | YEARS | | |
| | , , , , , , , , , , , , , , , , , , , | Jer | Se uentially list conditions if any, leading to immediate cause. Enter Underlying | | | , , , , , | | | /// | | |
| | cuted | Examiner | Cause (Disease or injury that initiated events | | | | | | | | |
| 0/00, | ficate be executed physician and s the burial-transit | EX | resulting in death) Last Due to (or as a consequence of): | | | | | | | | |
| 00 | icate physi s the l | dical | d | | | | | | | | |
| J. DOX (| sician: The law requires that the death certific certificate has been signed by the attending rector, page 2 should be detached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 2 ☐ Unknown 23c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown | 23d. Date of de Month | elivery Day Year | | | | | | |
| L. | hat the | Phy | Part II. Other significant conditions contributing to death but not re | sulting in the u | nderlying cause giv | en in Part I | 23e Did to | bacco use contribute | to the cause of death? | | |
| ecords, | equires ten signe | ed by | RENAT FALLURE | _ ~ | Tracing dauge giv | on mir dit i. | 1 🗆 Y | | Probably 4 ☐Unknown | | |
| Ē | The law rie has be | Completed | | | | | | sy prior to med? death? | | | |
| ומ | ian: rtifical tor, p | ø | 25. Was case referred to medical | | | 26. Place of Dea | 1 Yes ath (Check only o | 24 No 1 □ Ye | s 2 No | | |
| > | Physical this ceral direction | To B | examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ | ☐ ER/Outpatier | nt 3 DOA Oth | | | ence 6 Other (Sp. | ecify) | | |
| 5 | nding Pi th. :: After the e funeral | | 27. Manney of Death 1 Matural 5 Pending (Month, Day Year) 2 Accident investigation | 28b. Time of Injury | Wor | y at | | ow injury occurred | | | |
| | To the Hospital or Attending Physician: The within 24 Hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At h building, etc. (Spec | nome, farm, str | reet, factory, office | | 28f. Location (S City or Tow | itreet and Number or F rn, State) | Rural Route Number, | | |
| | e Hospit: 24 hours e Funera letely fille | edical C | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my kn (Check only one) 2 Medical Examiner: On the basis of examinand manner stated. | owledge, death | h occurred at the tir | ne, date and place pinion, death occ | e, and due to the urred at the time, | cause(s) and manner a date and place, and du | as stated. le to the cause(s) | | |
| | Within To th To the Compile Compile | Me | 29b. Signature and title of certifier | | 29c. Licens | | | 29d. Date signed (Mor | th, Day, Year) | | |
| | - | | | MD | Dy | 2096 | | 2-12-1 | 58 | | |
| | | | 30. Name and address of person who completed cause of death (Ite | m 23a) (Type, | Print) | | | | | | |
| | | | Rajbinder S. Gill, M.D. 24035 | | Notch Ro | ad, Holl | ywood, M | D 20636 | | | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) 32. Registrar's Sign | ature Company | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 1602 PM MORRIS MUREK /Medical 2m2 February 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day Year) 01/13/1952 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Days Hours 56 Washington, DC 215-58-8598 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Y Yes 2 No Director MD Montgomery North Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14705 Chisholm Landing Way 20878 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Self-Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leon Murek Chasia Guker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14705 Chisholm Landing Way, N. Potomac, MD 20878 Sally Murek - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)

Garden of Remembrance 02/05/2008 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Clarksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** VENTRICULAR TACKTY CORDIA /Medical Due to (or as a consequence of): **Examiner** MYCOSCAPYM INFORCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed the attending physician and hed for use as the burial-transit TUFECTION Due to (or as a consequence of): Physician/Medical MOSRY'S DISTAGE IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) i signed by the a ld be detached fo 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 1X Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🔀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: 1 Natural 2 Accident (Month, Day Year) Iniury 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours after deatl Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 7 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. one) 29c. License number 29d. Date signed (Month, Day, Year)

State Registra

29b. Signature and title of certifier

FEB

31. Date filed (Month, Day, Year) 32 Registrar's Signature 07

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TY lorons, MO, MPH

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

P0065830

February 2

ROCKULLE MD

2008

State of Maryland / Department of Health and Mental Hygiene 05357 1- State amend #5 Per FH G877 3/04/08 Hertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2008 8:20 P M February 4, Conrad Peter Mejac /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Collingswood Nursing Center Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Days Hours 85 5, **Director** Oct. 1922 Slovenia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland | Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7 Cloverbrooke Court Funeral 20854 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2K Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White δ 3 Widowed 4 Divorced "natural" Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) other than the Chief of Slovenian Section Voice of America 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental I Peter Mejac Leopoldina Bajda traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 Is
any injury or other trau
once. Mary F. Mejac (Spouse) 7 Cloverbrooke Court, Potomac, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 □ Cremation 3 □ Removal from State Feb 9,2008 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) John's Cemetery 22. Name and Address of Facility Devol Funeral Home 10 East Deer Park Drive 21. Signature of Funeral Service Lice Gaithersburg, MD 20877 2 a. P. 1. Enter tile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help tailure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Caust (Final disease Trondition resulting in death) **Physician** Endstage Liver Disease /Medical Due to (or as a consequence of) Examiner Sensis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause October of injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed physician and s the burial-transit resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical as inding I 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atter for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown signed by that be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Liver Cell Failure 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2x No 24a. Was an certificate has trector, page 2 s autopsy 1∐ Yes 2 🔀 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Yes 2 No ٩ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident after death Director: filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only the and manner stated. 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) D62435 February 5, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sayed Elsayyad, M.D. 9715 Medical Center Drive, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 1:00 P M FEB. 3, MATTHEWS 2008 HELEN D. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGES Laurel Regional Hospital Laurel If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 27, 1954 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Months Hours 1 ☐ M 2 🔀 F Yrs. Maryland Director 218-66-4116 53 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 Is marked other than "nature!" ----10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Xes 2 No Director MD Prince Geo. Laurel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 3504 Spring Road 20724 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Never Married 2 Married Black 1 ☐ Yes 2 ☒ No Specify. þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Weis Market 12th Cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Powell Glenwood Matthews 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8469 Pioneer Road, Severn, MD 21144 Arthur Thomas (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 2/9/08 Zion Cemetery Laurel, MD Mt. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee SNOWDEN FUNERAL HOME, P.A. 22. Name and Address of Facility 246 N. Washington St, Rockville, MD 20850 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) cardiovas Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical use as 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown Part Ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Yes 2 ER/Outpatient 2□ No 3∏ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 Inpatient 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 24 hours after death. e Funeral Director: After (Month, Day Year) injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 Bate signed (Month, Day, Year) 29b. Signature and title of 29c. Iricense number

Registrar

State

30. Name and address of person who/completed

Year)

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31. Date filed (Month,

1185

2008

cause of death (Item 23a) (Type, Print)

3001

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 130 PM 2008 FEBRUARY /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death County of Death Examiner WASHINGTON NEDICAL GLEN BURNIE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 9, 9. Birthplace (State or Foreign Country) New York Social Security Number Age (In yrs. last birthday) **Funeral** Days ^{Year)} 1948 1 M 2 □ F 59 091-42-2942 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
The part of Health and Mental Hygiene.
The portant: If liem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumafte event, the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Anne Arundel Crofton Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2310 Bellow Court 21114 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2X No 21215-0036 Specify. Specify: White þ 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) General Labor Laborer 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Harold T. McGuire Catherine Ann Maxwell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son James J. McGuire, Jr. 2310 Bellow Court Crofton, MD 21114 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 MRemoval from State 4 ☐ Donation 5 ☐ Other (Specify) Breslau Cemetery 2/9/2008 Lindenhurst, NY 21. Signature of Funeral Service License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC /Medical Due to (or as a consequence of): Examiner MATAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical as IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 2 No 1∐ Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 4 hours after death 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of pertifier, 29d. Date signed (Month, Day, Year) 0055703 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALDMONE

State Registrar

2008 FEB 1 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

WASHINGTON

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| altimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menhal Hygiene. I Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ | Removal from State | 20b. Place of Dispo cemetery, cre | osition (Name of matory or other pla | ace) | Date | 20c. Locati | ion - City or To | own, State | |
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| Box | death e atter | iciar | in the past 12 months? | 23b. Was decedent pregnant in the past 12 months? | | | | | | | Day Year | |
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| | To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page | | | ysician: To the best of miner: On the basis of e | | | | | | | | |
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|) | (5) | | 30. Name and address of person who | | th (Item 23a) (Type, 474 GRE | | (PUTTER | - DEIVE | SUIT | | EDNBELT, M | |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32. Registrar | s Signature | | 200,0 | | 7100 | | WILD | |
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| N. II | Dhariai | | 1. Decedent's Name (First, Middle, Last) | | | | | 2. Date of De | | Year | 3. Time of Death |
| | Physici /Medic | | JOHN NIVE | TY | | | | FEBRUI | 1RYZ | 2008 | 915PM |
| | Examin Funeral Director | er | 4a. Facility Name (If not institution, give street and number 12: NOPL NOPL NOPL NOPL NOPL NOPL NOPL NOPL | | OWTCE last birthday) Yrs. | If Under I Year Months Days | r Location of Deat WA PO LI If Under 24 Hrs Hours Min. | S 8. Date of Bir | th /g | 9. Birthp | ARUNOEL place (State or Foreign party) IL |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | 10c. City | , Town or Loc | ation | | | | 1 | 0d. Inside City Limits |
| | Maryla -f sho ied at | tor | MD Anne Arundel | 5 | Severna | Park | | | | | 1 □Yes 24□No |
| | th the or 28a e notii |)irec | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizer | of What Cour | ntry? |
| | ath wil | ral | 41 McKinsey Rd. | | | | 1146 | | | USA | |
| 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any filury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 4 □ Divorced 1 □ Was Dec. Armed Fc. It ☑ Yes. If Yes, Gi. Year or D | 2□No Www. | JII | Vas Decedent of H Yes, specify Cuba ☐ Yes 2 1 No | lispanic Origin? (s an, Mexican, Puei Specify: | Specify Yes or No rto Rican, etc.) | | Race - Americ Black, White, pecify: White | etc. |
| 5-0 | "natu | letec | 15. Decedent's Education (Specify only highest grade completed) | | 16a. Deced | ent's Usual Occup kind of work done OO NOT use retired | ation during most of wo | orking | 16b. Kind | of Business/In | dustry |
| 121 | within ene. than he Me | Completed | Elementary/Secondary (0-12) College (| I-4or 5+) | | irector | a) | | bΔ | vertisi | ino |
| d 2 | e filed al Hygi other vent, t | Be Co | 17. Father's Name (First, Middle, Last) | | | III | 18. Mother's Na | me (First, Middle | | | |
| ylaı | should b ind Ments marked umatic e | To E | Joseph Kirby | | | | | vieve McI | | | |
| , Maryland | 1 and 2 sh Health and tem 27 is m | | 19a. Informant's Name/Relationship (Type. Print) John T. Muety Son | | 604 Y | awl Ct. | | olis, MD | 21409 | | |
| Baltimore, | Pages 1 nent of He int: If iten iry or oth | | 20a. Method of Disposition 11☑ Burial 2 □ Cremation 3 □ Removal from | State C | emetery, crem | sition (Name of natory or other place | 1 1 | Date | | ion - City or To | |
| Itim | permit. Pag Department Important: I any Injury o | | 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee | A11 | | s Cemete | | • | | laines, | |
| Ba | permit. Departr Importa any Inji | | Date 2 M/ | | 1 | Ridgely | | nnapolis | | | ., I .A. |
| | Physician /Medical Examiner | | Due to | | ROVASO | er the mode of dyin | | | rrest, | | Approximate Interval Between Opset and Death |
| 3. | pe sit | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events c. | (or as a consequ | uence of): | | | | | | |
| | icate be executed physician and s the burial-transit | Examiner | that initiated events resulting in death) Last C Due to | (or as a consequ | uence of): | | | | | | _ |
| 68760, | e be e /siciar e buris | dical | | | | | | | | | |
| P.O. Box 68 | The law requires that the death certificat ite has been signed by the attending phyage 2 should be detached for use as the | Physician/Medi | in the past 12 months? | come pf pregna birth 2 Feta nant at time of do own | Ideath 3 | Ectopic pregnancy Other (specify) | / | | 23d | I. Date of delive | ery Day Year |
| | ss that jned b | by Pł | Part II. Other significant conditions contributing to d | eath but not resu | ulting in the un | derlying cause giv | en in Part I. | 23e. Did | tobacco use | contribute to t | he cause of death? |
| ord | w require been sig should b | ted k | DementiA | | | | | 1 🗆 | Yes 2 | √0 3 Prot | pably 4 □Unknown |
| al Records, | | Completed | TYPE TWO DIAB | 0405 | MOL | LITUS | | 24a. Was auto perfo 1∐ Yes | | prior to co death? | ppsy findings available mpletion of cause of |
| Vital | Physician: this certificatal director, | o Be | 25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 | Inpatient 2 🗗 | EB/Outpatient | 3 DOA Oth | or: | eath <i>(Check only o</i> Home 5□ Resi | | Other (Sees) | E.A. |
| וסר | a + E | n: To | 27. Manner Death 28a. Date | | 28b. Time of Injury | 28c. Injur Wor | | 28d. Describe | | | у/ |
| sior | ending leath. | atio | 2 Accident investigation | | | M 1 🗆 | Yes 2 □ No | | | | |
| Division | To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer | Certification: | determined 286. Place | of injury - At ho ng, etc. (Specify | ome, farm, stre | eet, factory, office | | 28f. Location (City or To | Street and N wn, State) | lumber or Rur | al Route Number, |
| | he Hospi n 24 hou he Funer pletely fill | Medical | 29a. Certifier 1 Certifying Physician: To the control one) 1 Medical Examiner: On the control one) | | | | | | | | |
| | X Virginity of the state of the | 3 | 29b. Signature and title of certifier | lh 1 | 0 | 29c. Licens | e number 4636 | 0 | 1-elu | igned (Month, | Day, Year) 2008 |
| | 456 | 7 | 30. Name and address of person who of impleted cause | se of death (Item | 23a) (Type, F | Print) Vore | PANS/ | HIGHINA | Mhu | JPS VIIL | 5, 2008 MDZIK8 |
| | Sta | | | gistrar's Signa | | | | · carrend | 1-11-11 | | |
| DH | Registr MH 17 Rev 1/2 | -1 | FEB 0 6 2008 | lave, | K A | nout. | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #5, perFH,g876, 2/26/08 TT Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 4, 6:23 A^{M} Mary Louise McDonough February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7500 Old Laurel Bowie Road Bowie Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days 1□M 2□F Hours 79 **Vrs** Director 579-38-09/19/1928 Washington, D.C. Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland (Prince George's Bowie 10e, Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 7500 Old Laurel Bowie Road 20715 U.S.A.

14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☑ ★ arried Baltimore, Maryland 21215-0036 1 ☐ Yes 21分No Specify: þ Specify: White 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked any injury or any injury or any injury or any 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Erwin Joseph Kramer Eloise Jenkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7500 Old Laurel Bowie Road, Bowie, MD 20715 Francis X. McDonough/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veterans
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State vecerans 02/08/2008 Crownsville, Maryland 22. Name and Address of Facility Robert E. Evans Funeral Home 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 16000 Old Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Ovarian 7 man ths /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Usease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner g physician and ss the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as ding IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient ည 3 DOA Manner of Death
 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29b. Signature and Me of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 131600

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of

31. Date filed (Month, Day, Year)

4201 Mitchell ville

Bonie, md 20716, George Cavanaugh .M.D.

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

| | | | For State Registrar | | State o | f Marylan | | artment o | | | lental Hy | /giene Reg. No | 21111 | 8 | 05363 |
|----------------------------|---|-------------------|--|--|--|--|---------------------------------------|---|---------------------------------------|------------------------|--------------------------------------|-------------------|---|--------------------------------|--|
| Н | Physici | an | 1. Decedent's Nam | | • | | | | | | 2. Date of Do | eath Da | у Ү | ear | 3. Time of Death |
| · Sano | /Medic Examir | al | 4a. Facility Name (| | | | | | vn, or Location | on of Death | Feb. | | 200 County of Anne | Death | 1009p ^M del |
| | Funeral Director | | 5. Social Security N 577-18-0 | 1909 6. | Sex 1 □ M 2 X F | 7. Age (In yrs. I | ast birthday) Yrs. | If Under 1 Y Months D | ear If Und | der 24 Hrs. rs Min. | 8. Date of Bi (Month, D May 01 | rth ay, Year, | 906 M | . Birthpla Countr lary I | ce (State or Foreign y) and |
| | Maryland -f show iled at | tor | Usual Residence o 10a. State MD | Decedent 10b. County Anne A | rundel | | , Town or Lo | | | | | | | 100 | d. Inside City Limits 1 ☐ Yes 2 🌠 No |
| | leath with the Marylan ns 23a or 28a-f show must be notified at | ral Director | 10e. Street and Nu 1069 Li | | gothy Vie | €W | | 10f. Zip Co | ^{de} 409 | | | _ | tizen of Wha | at Countr | y? |
| 920 | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 ☐ Never Mari 3 ☒ Widowed | ried 2 Married 4 Divorced | Armed Fo | 2 X No ve | | Was Deceden If Yes, specify 1 ☐ Yes 2√2 | | | ecify Yes or N Rican, etc.) | 0- | 14. Race - Black, Specify: | America White, et | tc. |
| 21215-0036 | within 72 ho lene. than "natu the Medical | Completed | (Specific Specific Sp | 15. Decedent's cify only highest o andary (0-12) | Education grade completed) College (1 | 1-4or 5+) | 16a. Dece (Give life. | dent's Usual O kind of work o DO NOT use r Nurse | ecupation lone during n etired) | nost of worki | ing | | ind of Busin | | istry |
| Maryland 2 | 12 should be filed within in and Mental Hygiene. 7 is marked other than "raumatic event, the Mec | To Be Co | 17. Father's Name Edward | | st) | 18. Mother's Name Kather | | | | | | | | | |
| Mary | 2 sho and h is ma rauma | • | 19a. Informant's N | | , ,, | | | ng Address (Si | | | | | | | |
| nore, N | ages 1 and on tof Health it item 27 or other tr | | | position Cremation 3 | ☐Removal from | State 20b. P | lace of Dispo emetery, cre | osition (Name of matory or othe | of r place) | Feb. | 06, | 20c. L | s, MD 21409 Location - City or Town, State itland, Maryland | | |
| Baltimore, | permit. Pages Department of Important: If i any injury or once. | | 4 □ Donation 21. Signature of Fi | 5 Other (Speuneral Service Lines) | | Ced | 3 | ll Ceme Name and A Sarranc 195 Gov | ddress of Fa | ons, P | .A. Se | verna | a Park | Fur | neral Home |
| | Physician | | 23a. Part I. Enter shook, or hea Immediate Cause disease or condition | (Final | | caused the death each line. | . Do not en | | | | | | - | | Approximate Interval Between Onset and Death |
| | /Medical Examiner | 4 | resulting in death) | - 1 | Due to | (or as a consequ | ience of): | | | | | | | | |
| | uted d ansit | Examiner | Sequentially list co if any, leading to in cause. Enter Undo Cause (Disease or that initiated event | onditions, nmediate erlying r injury | bDue to | (or as a consequ | uence of): | | | | | | | | |
| 8760, | certificate be executed nding physician and use as the burial-transit | | resulting in death) | Last | Due to | (or as a consequ | ence of): | | | | | | | | |
| P.O. Box 6 | death certifii e attending p d for use as | Physician/Medical | IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown | ? months? □ No | 1 ☐ Live b | tcome pf pregna birth 2 Fetal nant at time of de own | death 3 | ⊒Ectopic pregr ⊒ Other <i>(speci</i> | | | | | 23d. Date o Month | | y Day Year |
| | w requires that the de been signed by the should be detached | | Part II. Other signi | ficant conditions tension | s contributing to de | eath but not resu | Ilting in the u | nderlying caus | e given in Pa | art I. | | | | | e cause of death? |
| Reco | e law has be je 2 sh | Completed by | | nary Arte | ery Disea | ase | | | | | 24a. Was auto peri 1∐ Yes | opsy formed? | prid dea | or to com ath? | sy findings available pletion of cause of |
| /ita | ilcian: Th certificate ector, pag | Be C | 25. Was case refe examiner? | | | | | | | lace of Deatl | (Check only | | | | |
| Division or Vital Records, | aling Phys 1. After this funeral dii | tion: To | 1 ☐ Yes 2X 27. Manner of Dea 1 X Natural 2 ☐ Accident | | 28a. Date (Mon | Inpatient 2 of Injury th, Day Year) | ER/Outpatier 28b. Time o Injury | nt 3 □ DOA f 28c. M | Other: 4 X Injury at Work? 1 Yes 2 | | me 5 ☐ Res 28d. Describe | | | | |
| Divisi | or Dir | Certification: | 3 ☐ Suicide 4 ☐ Homicide | 6 Could not determine | be 28e. Place | of injury - At ho ing, etc. (Specify | | eet, factory, of | ffice | | 28f. Location City or To | | | or Rural | Route Number, |
| | To the Hospital within 24 hours a To the Funeral I completely filled | Medical (| 29a. Certifier (Check only one) | 2 Medical Ex | Physician: To the aminer: On the b and man | | | vestigation, in | my opinion, | death occur | | e, date ar | nd place, an | d due to | the cause(s) |
| | To To | × | 29b. Signature and | title of certifier | 44 | mi | ND | | 636C | er | | | ate signed (| | |
| | | | 30. Name and add | ress of person wh | no completed caus | se of death (Item | 23a) (Type, | Print) | | | | | | | |

Registrar

State

31. Date filed (Month, Day, Year) FEB 0 6 2008

Michael A. Ankrom, M.D. 8601 Veterans Highway Millersville, MD 21108

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Pear 11, 2008 John Francis Pingleton 7:18 PM 4a, Facility Name (If not institution, give street and number) 4c. County of Death 4h, City, Town, or Location of Death St. Mary's St. Mary's Hospital Leonardtown 8. Date of Birth (Month, Day, Year June 15, 1 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours Min. 1**X** M 2 □ F 72 217-34-0944 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland St. Mary's Clements 1 ☐ Yes 21 No 10e. Street and Number 10g. Citizen of What Country? 23621 Budds Creek Road 20624 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Trade Union Elementary/Secondary (0-12) College (1-4or 5+) Shipping/Receiving Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Austin Pingleton Julia Helen Hill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clements, MD 20624 Sarah Jean Pingleton / Wife P.O. Box 24 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sacred Heart Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State February 15, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Bushwood, Maryland 4 Donation 5 Dother (Specify) 2008 21. Son of Funeral Service License 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P. P.O. Box 270 _Leonardtown, MD 20650 Michael ardine 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SPIPATORY Due to (or as a consequence of): WIETABOLIC HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MITORY 1 ☐ Yes 2 ☐ No 3 ☐ Ptobably 4 ☐ Unknown ETFUSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

show at r 28a-f sh notified

or be

permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 230 any injury or other traumatic event, the Man

for Medical Certification: To Be

Physician/Medical

Completed by

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier

funeral

death certificate be executed after death

Hingleton O Vital John Division

To the Hospital within 24 hours a To the Funeral I

State

FAJSINDER 31. Date filed (Month, Day,) Year) 3

determined

MIS

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) D8091. 2-12-08

SMAH ASSOCIATES HOLIYWOOD MD 20236

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

GILL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | 1 - For State Registrar | State of Maryla | | artment of H rtificate of L | | | giene Z Reg. No. | 008 | 05365 |
|----------|---|----------------|---|---|--|--|--|--|---------------------|--|---|
| ı | Physici | an | 1. Decedent's Name (First, Middle, La | st) | | | | 2. Date of De | ath Day | Year | 3. Time of Death |
| | /Medic | | Vivian H. | | llins | | | | uary 4 | 4, 2008 | 8:44a ^M |
| | Examin | er | 4a. Facility Name (If not institution, giv | | | 4b. City, Town, or | | | 4c. Co | unty of Death | |
| 6 | Funcion | | Holy Cross Hospi 5. Social Security Number 6.5 | | s. last birthday) | If Under 1 Year | Spring If Under 24 Hrs. | 8. Date of Birt | h | | gomery |
| | Funeral Director | | | 1□M 2⊠F 88 | Yrs. | Months Days | Hours Min. | (Month, Da Jan. 15 | v, Year) | Cour | ntry) Jersev |
| n | pu , | | Usual Residence of Decedent | 10- (| No. T. | | | | | | |
| | show show | 'n | 10a. State 10b. County | | City, Town or Lo | | | | | 1 | 10d. Inside City Limits 1 ☐ Yes 2 🔀 No |
| | the M 28a-f lotifie | Director | Maryland Montg 10e. Street and Number | omery | Sil | ver Sprin 10f. Zip Code | g | | 10g Citizon | of What Cour | |
| | death with the Maryland ms 23a or 28a-f show r must be notified at | Ö | 1604 Ladd Street | | | 20902 | | | USA | | my. |
| | death | Funeral | 11. Marital Status | 12. Was Decedent Ever in Armed Forces? | U.S. 13. | Was Decedent of His If Yes, specify Cuba | spanic Origin? (Sp | ecify Yes or No | 14. | Race - Americ | |
| õ | 2 should be filed within 72 hours after death with the Marylan and Mental Hyglene and Mental Hyglene is marked total Hyglene "ratural", or items 23a or 28a-f show Is marked to the Medical Examiner must be notified at aumatic event, the Medical Examiner must be notified at | y Fu | 1 Never Married 2 Married | 1 ∐ Yes 2 XX No If Yes, Give | | n Yes, specily Cuba 1 □ Yes 2xਾ No | n, mexican, Pueno Specify: | Hicari, etc.) | | Black, White, becify: B1 | etc. .ack |
| -003e | hours tural" al Exa | ed by | 3x Widowed 4 ☐ Divorced 15. Decedent's E | Year or Dates: | 16a Dacad | dent's Usual Occupa | tion | | | of Business/In | |
| Ċ | in 72 n "na Nedic | Completed | (Specify only highest gra | ade completed) | (Give | kind of work done d DO NOT use retired, | luring most of work) | ing | TOD. KING | Ji business/ini | dustry |
| 7 | d with giene ar tha the i | E O | Elementary/Secondary (0-12) | College (1-4or 5+) | | Adminis | trator | | Fed | leral G | Sovernment |
| 2 | al Hylland I othe | Bec | 17. Father's Name (First, Middle, Last |) | | | 18. Mother's Nam | | Maiden Su | rname) | |
| Z | ould by Ment arkect | 10 | Paul Harris | | | | Alice Ch | ampion | | | |
| Z Z | s 1 and 2 should f Health and Mer item 27 is marke other traumatic | | 19a. Informant's Name/Relationship (| | - | ng Address (Street a | | | - | | · . |
| ָב ט | 1 and 2 Health em 27 i | | Aleta Clark/Daug 20a. Method of Disposition | | 4940 Place of Dispo | S. East | End, Chi | cago, I | | s 6061 | |
| | ages ent of t: If it y or o | | 1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special | Jhemovai nom State | | sition (Name of matory or other place shington | ; Feb | . 9, | | , | |
| Daltillo | permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once, | | 21. Signature of Funeral Service Lice | nsee CAA | Cemeter | Name and Addres | s of Facility | - | | ni, Mar | yland |
| Ď | Deg any | | Volum | Hell | → If: | rancıs J. | Collins | Funeral | l Home Silver | Inc. | g, MD 20901 |
| | No. | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that caused the de- | ath. Do not ent | er the mode of dying | g, such as cardiac | or respiratory ar | rest, | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | a Congestive | | | | | | | Onset and Death |
| | /Medical Examiner | | resulting in death) | Due to (or as a conse | equence of): | | | | | | |
| | 24.25 | er | Sequentially list conditions, if any, leading to immediate | b. Due to (or as a conse | equence of): | | | | | | |
| | uted d ansit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | |
| Ś | an an | Еха | resulting in death) Last | Due to (or as a conse | equence of): | | | | | | |
| 0/00, | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit | edical | | ⊾d | | | | | <u>-</u> | | |
| 0 | ertific ling p | Mec | IF FEMALE: | 000 16 0 | | | | | | | |
| کا ا | w requires that the death certif been signed by the attending should be detached for use a | hysician/M | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome pf pregi 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of | tal death 3 | Ectopic pregnancy Other (specify) | | | 23d | Date of delive Month | ery Day Year |
| į | the d | ysid | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9□Unknown | death 5L | Other (specify) | | | | | |
| Ľ | s that ned b | by Pł | Part II. Other significant conditions | ontributing to death but not re | esulting in the ur | nderlying cause give | n in Part I. | 23e. Did to | bacco use | contribute to the | he cause of death? |
| COLOS, | equire en sig ould bo | ed b | Chronic Obstructiv | ve Pulmonary D | Disease, | | | 1 🗆 1 | ∕es 2 ∑ | jo 3□ Prot | bably 4 □Unknown |
| ט ט | law re as be 2 sho | Completed | Diabetes Mellitus | , Hypertension | 1 | | | 24a. Was | | 4b. Were auto | opsy findings available impletion of cause of |
| C | The cate h | Com | | | | | | perfo 1□ Yes | rmed? | death? | 2 □ No |
| V 110 | ician: Sertific ector, | Be | 25. Was case referred to medical examiner? | Hospital: | | Otho | 26. Place of Deat | | | | |
| 5 | Physical dir | T. | 1 ☐ Yes 2 ☐ No 27. Manner of Death | 28a. Date of Injury | ZER/Outpatien 28b. Time of | | 4 LI Nursing Ho | me 5 Residence Residence Residence 28d. Describe | | | ý) |
| 5 | nding h. : After fune | tion | 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Day Year) | Injury | Work | ?" (es 2 □ No | Zou. Describe i | iow injury or | curred | |
| 2 | or Attending Physician: The lavalter death. Director: After this certificate has in by the funeral director, page 2 | ifica | 3 ☐ Suicide 6 ☐ Could not be determined | e 28e. Place of injury - At | home, farm, stre | | | | | umber or Rura | al Route Number, |
| 2 | tal or rs afte ral Dir led in | Certification: | 4 _ Hornious | building, etc. (Spec | | | | City or Tou | m, State) | | |
| | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director directors and directors directors. | | (Check only 2 Medical Exal | nysician: To the best of my kr miner: On the basis of examin | nowledge, death | occurred at the time | ne, date and place, pinion, death occur | and due to the red at the time. | cause(s) an | d manner as s | itated. |
| | thin 2, the I mplet | Medical | 29b. Signature and the of certifier | and manner stated. | | 29c. License | | | | | |
| | Z = Z = Z | | 200. Signature and the discertifier | | Ne-D | 200. 200186 | d52861 | | | igned <i>(Month,</i> bruary | 5, 2008 |
| | 3 | | 30. Name and address of person who | completed cause of death (Its | | Print) | | | | | |
| | | | Asha Vali, MD | 9801 Georgia | a Avenue | | Spring, | MD 2090 | 2 | | |
| | Sta | 1 | 31. Date filed (Month, Day, Year) | 2. Registrar's Sign | nature | £, | | | | | |
| | Registr | ar | FEB 07 2008 | Bellen St. | A STATE OF THE PARTY OF THE PAR | | | | | | |

State of Maryland / Department of Health and Mental Hygiene UU 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** PATRICIA February W. POGUE 2008 10:49 A™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Alfred House Elder Care Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 76 577-42-0907 Director June Washington, D.C Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location I7 is marked other then "natural", or iteme 23a or 28a-f shov traumatic event, the Maraical Examiner must be notified as 28a-f shov Md. Montgomery Rockville 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20855 United States 18110 Cashell Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No Baltimore, Maryland 21215-0036 White Specify: Specify: If Yes, Give Year or Dates: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Travel Specialist 12 permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event 2008: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Sablurova Anna Windsor Matt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3908 Mt. Olney Lane, Olney, Md. Richard L. Eisenacher, Jr. / Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1XX Burial 2 □ Cremation 3 □ Removal from State Brookeville, Md. 2/12/08 4 ☐ Donation 5 ☐ Other (Specify) Salem Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Muriel H. Barber Funeral Home
P. O. Box 5038, Laytonsville, Md. 20882 au 0-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart railure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Respiratory Infection 1 Week /Medical Due to (or as a consequence of): Examiner 5 Years Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed as the burial-transit 4 Years Parkinson's Disease Due to (or as a consequence of) attending physician Physician/Medical Generalized Arteriosclerosis 4 Years IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes, Hypertension, 3 ☐ Probably 4 Munknown cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No Be Completed Skin Ulcer (Heel) 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No certificate has Hypercholesterolemia 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Assisted examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Mapner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25410 February 8, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Drive, Olney, Md. Oliver J. Lawless, M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

Division of Vital Records, P.O. Box 68760

32. Registrar's Signature

2008

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene ! | | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 5.30AM MAN YOUNG FEB 8,2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 4335 WINTERODE WAY 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 1**∑** M 2□ F Months Days Hours 77 220 72 3906 Yrs. Director JAN 6 1931 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Maryland ment of Heatth and Mental Hygiene.
ant: If Item 27 is marked other than "naturel; or Hems 23a or 28a-f ehow ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits fX☐ Yes 2☐ No Director MD BALTIMORE Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 USA 4335 WINTERODE WAY Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: ASIAN Š 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE AUTO MECHANIC 12 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MYONG YUN CHUNG SIK PAK HWA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 14061 MONTICELLO DR COOKSVILLE MD 21723 JUNG HUN PAK / 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ➡Burial 2 ☐ Cremation 3 ☐ Removal from State 2/10/08 MARRIOTTSVILLE MD 5 Other (Specify) CRESTLAWN MEMORIAL 21. Signature of Funer J Service A 22. Name and Address of FacilityCHARLES HINDS FUNERAL SERV 12303 KAYAK DR UPPER MARLBORO MD 20772 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Non-Sugl/ Cell Lung Lymer 6 Montes Examiner Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed the bunel-trensi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): ate has been signed by the attending p page 2 should be deteched for use as Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 → Yea 2 □ No 3 □ Probably 4 □ Unknown ٥ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? After this certificate has 2 LA 1 ☐ Yes 2 ☐ No 1 Tyes To the Funeral Director: After this certifics completely filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 🗌 Yes 2 🗆 No death. 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a Medical 1 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) huladopho Road # 208, Baltimore, MOZ1237

DHMH 16 Rev 6/95

State

Hegistrar

31. Date filed (Month, Day, Year)

1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 55 AM 2008 Constance Debra Popan TEBRUARY 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CENTER ARUNDEL BURNIE ANNE BALTIMORE WASHINGTON MEDICAL 6LEN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country)
 PA 7. Age (In yrs. last birthday) Social Security Number Months Days Hours 1 □ M 2 🖫 F 63 165-36-3070 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 ☐ Yes 🛠 🛣 No Odenton Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code USA 1318 Farrara Drive 21113 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2X Married White 1 ☐ Yes 2X No 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Josephine Naprakowski Robert Gabriel Blaskovich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Odenton, MD 21113 1318 Farrara Drive Husband Geza Popan 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 2/9/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Fonetal Service License all Annapolis, MD 21401 12 Ridgely Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line. PNEUMOWIA Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 3 Ectopic pregnancy 4⊡Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use ontribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No 1□ Yes 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Division or Vital Records, P.O. Box 68760, has been sig ge 2 should b

Physician /Medical

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

Directo

Funeral

ģ

Completed

Be

MD

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

DUSTANGE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be 1 🗌 Yes P 27. Manner of Death Certification: 1 Natural 5 Pending investigation М 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tsion Berhane, MD

DHMH 17 Rev 1/2001

State Registrar WASMINGTON

BALAMORE

FEB 0 6 2008

31. Date filed (Month, Day, Year)

MEDICAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Belle 10:45 P February 4, 2008 Rosen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Brooke Grove Nursing and Rehab. Sandy Spring Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Funeral Hours 1 □ M 2 🖾 F Days Yrs. Director 219-34-8059 96 Feb. 1, 1912 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 X Yes 2 No Director MD Montgomery Silver Spring 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 341 Soapstone Lane 20905 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 Secretary United States Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be ealth and Mental Morris Friedlander Sarah Hyman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health i Howard N. Rosen - Son 341 Soapstone Lane Silver Spring, MD 20905 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any Injury or ot
once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/7/2008 Judean Mem. Gdns. Olney, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike Rockville, MD 20852 23a. Fart1. Enter the Base, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and the burial-tran certificate be exec Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dehydration 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No End stage dementia 24a. Was an autopsy performed? 1☐ Yes 2 🔯 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 ☐ Yes 2 X No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred a or Attending P after death. I Director: After to in by the funera 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43202 February 5, 2008 WD 30. Name and address of person who completed cause of seath (Item 23a) (Type, Print) MD. Charlene Ozanne-Blankfard. 3305 N. Leisure World Blvd. Silver Spring, MD 20906 31. Date filed (Month, Day, Year) egistrar's Signature

DHMH 17 Rev 1/2001

Registrar

07

2008

FEB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Danie1 Rhode 8:00 FM ebruary 2009 /Medical County of Death Montgomery 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 89 1 **X**M 2 □ F 9/4/1918 Baltimore, MD Director 213-16-3628 Usual Residence of Decedent 10c. City, Town or Location r 28a-f show notified at 10d. Inside City Limits 10b. County ₩⊓Yes 2 □No Silver Spring Director Montgomery 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or 2 dical Examiner must be n 20906 United States 12801 Teaberry Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No WW II If Yes, Give Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo White Specify: þ 3√2 Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pest Control Owner permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other trailmast. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) David ''unknown'' Rosie "Unknown" 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2113 Carter Mill Way Brookeville MD 20833 Marty Rhode - Son 20b. Place of Disposition (Name of cemetery crematory or other place)
Shaarei Zion Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/4/08 Baltimore, MĎ 22. Name and Address of Facility 21. Signature of Funcial-Buttice License Tuyard Sagel Funeral Direction Incoms 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RESPIRATORY ACUTE HOURS FAILURE /Medical Due to (or as a consequence of): Examiner DAYS ACUTE RENAL FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine DAYS certificate be executed CONGESTIVE HEART FAIWRE and burial-trar Due to (or as a consequence of): Box 68760 attending physician VALUE 2I 20 MAT2 MONTHS CRITICAL ADRITC Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy for Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an pertormed certificate 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 2 funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Hospital or Attending Pl 24 hours after death.
 Funeral Director: After the 27. Manner of Death 28c. Injury at Work? Certification: After 5 ☐ Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Danje

Rhode,

To the Hospital or within 24 hours af To the Funeral D

Medical

State Registrar

OLD 31. Date filed (Month, Day, Year) FEB 0 7

29a, Certifier

8600

(Check only one)

29b. Signature and title of certifier



, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BETHESDA, MARYLAND

11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D63639

Dr. Pothu R. Nagabhyru

29d. Date signed (Month, Day, Year)

02/02/08

20814

05371 State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Jeffrey A. Ricks 6, 2008 0550 February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Takoma Park Montgomery Washington Adventist Hospital If Under 1 Year | ff Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 ☐ F Days Yrs. 578-90-0997 46 Director March 16, 1961 DC Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State in items 23s or 28s-f show 1 ☐ Yes 2 🕅 No Prince George's Riverdale Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 5505 Karen Elaine Drive #1006 20784 filed within 72 hours after death Hygiene. Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Yes 2 XNo ff Yes, Give Year or Dates: 1 Never Married 2 Marned ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: þ or then "natural", 3 Widowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Wallace Relocation, Elementary/Secondary (0-12) College (1-4or 5+) Distributor Packaging & Distribution 12th permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linjury or other treumatic event 900g. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cordelia Walker William H. Ricks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1513 Kempa Court Upper Marlboro, MD Cordelia Ricks/Mother 20b. Pface of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 02-12-2008 | Brentwood, MD 4 Donation 5 Other (Specify) Ft Lincoln Cemetery 22. Name and Address of Facility Marshall's Funeral Home, 21. Signature of Funeral Service Licenses 4217 9th Street, NW Washington, DC 20011 Approximate fnterval Between Onset and Death 23a. Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fmmediate Cause (Final disease or condition resulting in death) PHAI **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IMMUNE DEFICIENCY SYNDROME Examiner physician and s the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Dther significant conditions contributing to death but not 23e. Did tobacco use centribute to the cause of death? þ 21 No 3 Probably 4 Unknown should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 No 2 No this certificate 1 Tyes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2♥ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Matural Infurv 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 29c. License number FEBRUARY6, 2008 30. Name and address of person

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Cortificate of Death

Reg. No. 2008

05372

| Physician |
|-----------|
| /Medical |
| Examiner |

Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physiciar /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

| | • negistrar | | illioute of Boulif | ŀ | teg. No. 🛴 🔾 🔾 🔾 | 00011 | | | | | | | |
|--|---|---|--|---|---|--|--|--|--|--|--|--|--|
| cian lical | 1. Decedent's Name (First, Middle, Last) Katharine Roesler | | | 2. Date of Dea Month Feb | 03, 2008 | 3. Time of Death 7:50 P M | | | | | | | |
| iner | 4a. Facility Name (If not institution, give street and number) Genesis- Spa Creek | | 4b. City, Town, or Location of D | eath | 4c. County of Dea | | | | | | | | |
| i čel s | | o (In use leat histhday) | If Under 1 Year If Under 24 I | Hrs. 8. Date of Birtl | | | | | | | | | |
| l r | 218-30-6795 ^{1□M 2} AF 9 | e (In yrs. last birthday) 32 Yrs. | | lin. (Month, Day Dec. 07 | v. Year) Co | thplace (State or Foreign ountry) ryland | | | | | | | |
| | Usual Residence of Decedent | 100 City Town and a | a atia a | | | 404 testile Oils Circle | | | | | | | |
| tor | MD 10b. County Anne Arundel | Annapol: | | | | 10d. Inside City Limits 1 ☐ Yes 2X No | | | | | | | |
| 9 | 10e. Street and Number | 1 | 10f. Zip Code | | 10g. Citizen of What Co | ountry? | | | | | | | |
| Funeral Director | 85 Manresa Road | | 21409 | | USA | | | | | | | | |
| ne | 11. Marital Status 12. Was Decedent Armed Forces? | | Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, P | (Specify Yes or No- | 14. Race - Ame Black, Whi | | | | | | | | |
| 显 | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 | No | | 30110 1 110411, 0101) | | | | | | | | | |
| Completed by | 3 ▼Widowed 4 Divorced If Yes, Give Year or Dates: | | 1 ☐ Yes 2 🔀 No Specify: | | | hite | | | | | | | |
| ete | 15. Decedent's Education (Specify only highest grade completed) | Give | dent's Usual Occupation kind of work done during most of DO NOT use retired) | working | 16b. Kind of Business | rindustry | | | | | | | |
| 교 | Elementary/Secondary (0-12) College (1-4or | 5+) 1 | | | Home | | | | | | | | |
| Ö | 12 | l He | omemaker | | none | | | | | | | | |
| To Be (| 17. Father's Name (<i>First, Middle, Last</i>) William Lehr | | | Name (First, Middle, Bothe | Maiden Surname) | | | | | | | | |
| - | 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod | | | | | | | | | | | | |
| | Francis William Roesler Jr. | / | | Severna Pa | | | | | | | | | |
| | 20a. Method of Disposition | 20b. Place of Dispo cemetery, crei | sition (Name of matory or other place) | b. 08, | 20c. Location - City or | Town, State | | | | | | | |
| | 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Metro Cr | rematory 2 | 008 | Baltimore, | - | | | | | | | |
| | 21. Signature of Funeral Service Ucersee | | Name and Address of Facility Sarranco & Sons, 95 Gov. Ritchie | P.A. Seve | erna Park F | uneral Home | | | | | | | |
| | 23a, 1rt1. Eller the disease, or omplications that cause | | | | | Approximate | | | | | | | |
| | 23a. 7 rt1. Et er the disease, or omplications that cause shock, heart failure. List only one cause on each liter mediat, ause (Final | ne. | į | , | , , , | Interval Between Onset and Death | | | | | | | |
| | In mediat ause (Final sease condition results in death) a. Due to (or as a consequence or | | | | | | | | | | | | |
| | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): | | | | | | | | | | | | |
| ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Undersome injury | | | | | | | | | | | | |
| Examiner | triat initiated events | | | | | | | | | | | | |
| <u>a</u> E | Due to (or as | a consequence of): | | | | | | | | | | | |
| an/Medical | d | | | | | | | | | | | | |
| N. | IF FEMALE: 23c. If yes, outcome | pf pregnancy | | | 23d. Date of de | livery | | | | | | | |
| | In the past 12 months? | 2 Fetal death 3 | Ectopic pregnancy Other (specify) | | Month | Day Year | | | | | | | |
| Completed by Physici | 1 Yes 2 No 9 Unknown 9 Unknown | time of death 5 | | | | | | | | | | | |
| y Ph | Part II. Other significant conditions contributing to death b | ut not resulting in the u | nderlying cause given in Part I. | 23e. Did to | obacco use contribute t | o the cause of death? | | | | | | | |
| q p | HyperTension | | | 104 | es 2□No 3□P | robably 4 Unknown | | | | | | | |
| lete | O'STes authoritis | | | 24a. Was a | an 24b. Were a | utopsy findings available | | | | | | | |
| F | 310001111113 | | | | rmed? death? | utopsy findings available completion of cause of | | | | | | | |
| ပိ | Of Was assertered to modical | | | 1□ Yes | A□No 1□Yes | s 2□No | | | | | | | |
| Be | 25. Was case referred to medical examiner? Hospital: | | 0.1 | Death (Check only of | | | | | | | | | |
| 2 | 1 Inpati | | 1 3 DOA 4 HAVIrsir | | ience 6 ☐Other (Spe | ecify) | | | | | | | |
| ion | 27. Manner of Death 1 Natural 5 Pending (Month, Da | | Work? | 28d. Describe h | now injury occurred | | | | | | | | |
| cat | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of in | At home form at | | 001 1 10 10 | | 18 | | | | | | | |
| Certification: | determined 20e. Place of III | ury - At home, farm, str c. <i>(Specify)</i> | eet, factory, office | City or Tow | Street and Number or R vn, State) | ural Houte Number, | | | | | | | |
| Medical C | 29a. Certifier (Check only and and and and and and and and and and | of examination and/or in | h occurred at the time, date and p vestigation, in my opinion, death o | ace, and due to the occurred at the time, | cause(s) and manner a date and place, and du | s stated. e to the cause(s) | | | | | | | |
| Med | one) and manner st 29b. Signature And title of certifier | ateu. | 29c. License number | | 29d. Date signed (Mon | th, Day, Year) | | | | | | | |
| | In to Free W | 1-D | 017963 | | 2/4/0 8 | | | | | | | | |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) | | | | | | | | | | | | | |
| 1 | Joseph Friend 116 | 2 Perens | e Hary K | thu-po | lis, My- | 21401 | | | | | | | |
| tate | 31. Date filed (Month, Day, Year) 32. Region | ar's Signature | | V | , | | | | | | | | |

Me

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| 06-01060 | Please Type of Print in Black indelible ink. I | Ensure An Copies Are Legible. | | |
|--------------------------|--|-----------------------------------|--------|-------------|
| Daniel Joseph Ruskin | State of Maryland / Department of Hea | alth and Mental Hygiene | 000 | 0537 |
| 1- For Stat Registrar | Certificate of Dea | ath Reg. No. | 000 | 0007 |
| Physician/ 1. Decede | nt's Name (First, Middle,Last) | 2. Date of Death Month Day Yea | 0.5 | ne of Death |
| Medical Examiner Dan | iel Joseph Ruskin, Ir. | Fobruary 7 2008 | " 06 | 48 hrs |

| | | 1- For State Registrar | 000 0007 | | | | | |
|--|----------------|---|----------------------------|---------------------------------------|-----------------|-------------------------|-----------------------------|--------------------------------------|
| Physicia | | Decedent's Name (First, Middle,Last) | ath Day Year | 3. Time of Death | | | | |
| edical Exami | ner | Daniel Joseph Ruskin, | Jr. | | | Month February | 7, 2008 | 0648 hrs |
| | | 4a. Facility Name (if not institution, give street and number |) | 4b. City, Town, o | or Location of | Death | 4c. County of I Caroline | Death |
| | | 8255 New Bridge Road | | Denton | Tien . | out la Barasti | | 9. Birthplace (State or Foreign |
| Funeral | | | ge (In yrs. last birthday) | If Under 1 Ye | | 1 2 2 2 | 1 | Country) |
| Director | l | 045-54-2780 1X _{M 2} F | 44 | Yrs. | | April | U5 1963 V | Washington, DC |
| A | [| Usual Residence of Decedent 10a, State 10b, County | 10c. City, Town or Lo | action | | | | 10d. Inside City Limits |
| # # # # # # # # # # # # # # # # # # # | | Maryland Caroline | Denton | | | | | 1 Yes 2 X No |
| /land -f sho | į | | Deficon | 10f, Zip Code | | | 10g. Citizen of What | |
| Mary r 28a ed at | Director | 10e. Street and Number | | | | | | - |
| th the 23a o | = | 8255 New Bridge Road | . F | 216 | | in? (Specify Yes or N | U.S.A. | American Indian, Black, |
| ith wi | Funeral | 11. Marital Status 1 Never Married 2 X Married Armed Forces | ? | | | Puerto Rican, etc.) | White, | |
| or dea | ᇍ | 1 Yes 2 3 Widowed 4 Divorced If Yes, Give Year | 2 X No | Yes 2 X N | lo specific | | Specify: | White |
| rs aftural" | ā | 15. Decedent's Education (Specify only highest grade co | | dent's Usual Occup | | ind of work done | 16b. Kind of Busin | ness/Industry |
| 2 hou "nat | ğ | Elementary/Secondary (0-12) College (1-4 or | during | most of working li | | | Surveyi | ina |
| 336 thin 7 than edir | Completed | 12 | Surv | reyor | | | Sarvey | -11g |
| 5-00 ed wii lygier other | S | 17. Father's Name (First, Middle, Last) | | _ | 1 | s Name (First, Middle | | |
| 215 be fill ntal H rked | Be | Daniel J. Ruskin, Sr. | | | | la Ferri Rı | | |
| 3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eleath and Mental Hygiene. ttem 27 is marked other than "natural", or items 23a or 28a-f show any traumatic event, the Medical Examiner must be notified at once. | ို | 19a. Informant's Name/Relationship (Type, Print) | | | | ber or Rural Route Nu | | |
| MD d 2 st an 127 in 27 in an | | Kathleen Ann Ruskin/ wife | | | | ad; Dentor | | Dity or Town, State |
| s l an of Hea If iter | | 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from S | tate crematory or | position (Name of o r other place) | | | | |
| Page Page nent c | | 4 Donation 5 Other Specify: | | ss Cemet | | Feb 12 200 | | |
| Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medis 41 Examiner must be notified at once. | | 21. Signature of Funeral Service Licensee | - P | Name and Address | ass of Facility | fenbein Fu | uneral Hor | ne, PA |
| | Щ | 23a. Part I. Inter the disease, or complications that cause | | | | ensboro, N | | t Approximate Interval |
| Physician /Medical | | failure. List only one cause on each line. | d the death. Do not ent | er the mode or dyn | ig, such as G | ardiac or respiratory a | irest, shock, or hear | Between Onset and Death |
| xaminer | | Immediate Cause (Final disease or condition resulting in death) Due to (or as a con- | | Beauti | | | | |
| , | | h | sequence or). | | | | | |
| | ē | Sequentially list conditions, if any, leading to immediate Due to (or as a constant of the conditions). | sequence of): | | | | | |
| | Examiner | Course Erner Underlying Course (Disease or injury that initiated C. | | | | | | |
| ted msit | Exa | events resulting in death) Last Due to (or as a con | sequence or). | | | | | |
| n of Vital Records, P.O. Box 68760, time Physician: The law requires that the death certificate be executed the After this certificate has been signed by the attending physician and sinneral director, page 2 should be detached for use as the burial - transit | edical | X UNPENDED AMENDED 1.2 | 3a,Pt.II,27,2 | 28a-f per M | E g878 4 | 4/17/08 amh | | |
| 760, ficate be g physici the buri | Ned | | ome of pregnancy | | | | 23d. Date of c | delivery |
| 187 rtifica ing pl | M/us | 23b. Was decedent pregnant in the past 12 months? | 2 | Fetal death | 3 Ectopio | pregnancy | Month | Day Year |
| Box 687 he death certifithe death certifithe death certifithe death certifithed hed for use as the death dea | sici | 4 Pregnant a | at time of death 5 | Other (Specify) | | | 1 | |
| he dea | Physician | Part II. Other significant conditions contributing to dea | oth but not soculting in t | ho undorlying caus | e given in Pa | art I 23e Dio | tobacco use contrib | oute to the cause of death? |
| P.O. | β | | | | io given arre | | | Probably 4 Vunknown |
| S, C | ted | Hypertensive Atherosclerotic | Carutovascuta | ir Disease | | 24a. Wa | as an 24b. W | /ere autopsy findings available |
| OFC aw re tas be | ple | | | | | | | rior to completion of cause of eath? |
| Rec The 1 cate 1 | Completed | | | | | | s 2 No 1 | ✓ Yes 2 No |
| certifi ector, | Be (| 25. Was case referred to medical examiner? Hospital: | | | Other | (Check only one) | | - |
| Division of Vital Records, P.O. sat or Attending Physician: The law requires that the an or Attending Physician: The law requires that the an Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach | 2 | 1 Yes 2 No Inpat | tient 2 ER/Outpat | | niury at Work | Nursing Home 5 | Residence 6 | |
| n of 'ding Ph | ;: | 27. Manner of Death 1 Natural 5 Pending R 3.07 | r,Year) | ,, | Yes 2 X | | or now injury docume | |
| SiOl Attender death sector: | cati | 2 Accident Investigation Fnd 2/7/ | 08 Fnd 6: | :30a | | Unk | (Street and Numbe | er or Rural Route Number, City |
| S after | Certification: | Suicide b X Could not be | | street, ractory, onic | e building, c | or Town | | |
| ospit: | ညီ | 29a. Certifier | ind at home | courred at the time | date and ni | | | |
| Division To the Hospital or Attenditive within 24 hours after death To the Funeral Director: A completely filled in by the fu | Medical | one) 2 Medical Examiner: On the basis of ex | amination and/or inves | tigation, in my opin | ion, death o | courred at the time, da | ite and place, and di | ue to the cause(s) |
| To To | Mec | and manner states 29b. Signature and title of certifier | d | | ense number | | | ed (Month, Day, Year) |
| | | Dama my Dincenti, mit |). | 0. | C.M.E. | | February 8, | 2008 |
| | 1 12 | 30. Name and address of person who completed cause of | | | | | | |
| | 12 | Donna M. Vincenti, MD Assistant Med | | 111 Penn Stre | et, Baltim | ore, MD 21201 | | |
| | tate | | rar's Signature | | | | <u> </u> | |
| Regis | | | . M A | and a | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 25-28a per me, g876, p2/21/08dbh 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Walter E. Rejonis ebrunay 7 /Medical 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 1 ▼M 2 □ F 92 286-09-3288 April 11,1916 Director Ohio Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 1 Yes 2 No Director Maryland Washington Smithsburg 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code ns 23a or 7 15 Eckstine Court 21783 U.S.A. Funeral ural", or Items 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. Yes 2 No f Yes, Give X Year or Dates: , o. 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. þ 3 Widowed 4 Divorced White 'natural'. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Examiner Mining 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Rejonis Thelma Stankus ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains 15 Eckstine Court Smithsburg, Maryland 21783 Ethel M. Rejonis (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) February Powhatan Cemetery Powhatan Point, Ohio 11, 2008 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J.L. Davis Funeral Home DAVIS 12525 Bradbury Ave. Smithsburg, Maryland 21783 MO1414 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CERTIFICATION APPROVED BY MEDICAL EXAMINER Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to [or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of) the death certificate be Physician/Medical as ate has been signed by the attending page 2 should be detached for use as IF FEMALE P.O. Box 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 ☐ No 9□Unknown 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an 1□ Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No 2 ER/Outpatient 3 DOA this Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Matural Injury 01/30/2008 1 Yes 2 No 2 Accident Subject fell **Unknown**^M 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 15 Eckstine Ct. 4 Homicide **Home** Smithsburg, MD 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) FEB 2 1 2008

1

FEB 2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year Ruby Cathleen Sweeney February 11, 2008 6:45 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Leonardtown St. Mary's Hospital St. Mary s 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 🗓 F Director 78 <u> 217-26-8767</u> 07/11/1929 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notifled at 1 ☐ Yes 2 X No Director Maryland St. Mary's Mechanicsville 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code 26931 Holly Lane United States 14. Race - American Indian, Black, White, etc. Funeral 20659 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: <u>}</u> Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent 12 Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank E. Thomas 2 Hattie Lee Thomas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai once. David W. Sweeney/Son 37796 Lockes Crossing Road, Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Cem | 02/16/2008 Leonardtown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Brinsfield Funeral Home, P.A. Kyle S. Simons MO1206 22955 Hollywood Road, Leonardtown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Rospirator annea /Medical Due to (or as a conse mence of Examiner are CANTIOC Sequentially list conditions, if any, leading to influed at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of, Examine Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) a□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Z Unknown Completed obstructive 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2☑ No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature, and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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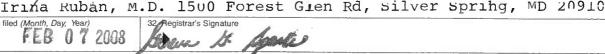
Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

Yo the Funeral Director: After this certificat in 24 hours.
the Funeral Directors of the Irectors of the Irec

> State Registrar

31. Date filed (Month, Day, Year) FEB 07

29b. Signature and title of certifi



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D63343

29d. Date signed (Month, Day, Year)

2/4/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 🗓 🗎 🗎 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Year **Physician** Febt. 2, 2008 3:05 P. M SHERWOOD Samue 1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Hillhaven Nursing Home Adelphi | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign | August Pay 10, 1911 | 1975 Our i 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 498-03-5954 96 Vrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ ... en pinury or other traumatic even. 10c. City, Town or Location 10a State 10h Counts 10d. Inside City Limits 1 Yes 2 No Director Adelphi MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20783 3210 Powder Mill Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? N□ Yes 2 □ No If Yes, Give Year or Dates: Army 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Completed by 3 X Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Attorney 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pearl (Unknown) Solomon Schevack ပ 19b. Mailing Address (Street and Number or Rural Route Number. City or Town, State Zip Code) 6219 Executive Blvd., Rockville, MD 20852 19a. Informant's Name/Relationship (Type, Print) Bob Morin / attorney 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \(\Delta Burial \) 2 \(\text{Cremation} \) 3 \(\text{Removal from State} \) King David Memorial Feb. 7, 2008 Falls Church, VA `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Alzheimer's Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of). attending physician for use as the buria Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. the a signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by Benign Prostatic Hypertrophy 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Coronary Artery Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 🂢 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide a Funaral 1 Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 o tha F 29b. Signature and title of o 29c. License number 29d. Date signed (Month, Day, Year) 2/6/2008 D55559 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Center, Greenbelt, MD Thomas Maslen, MD 31. Date filed (Month, Day, Year) Registrar's Signature State 0 7 2008 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day 4, 2008 February 1:25 A. M Bernard M. Schneider 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Arcola Nursing & Rehabilitation Ctr. Montgomery Silver Spring 8. Date of Birth (Month, Day, Yes Tune 21, 6. Sex 1. M 2 □ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year) 1929 Months Days Hours Wash. D. C. 78 578-40-2282 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Yes 2□No Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 U. S. A. 15300 Pine Orchard Drive, # 1E 12. Was Decedent Ever in U.S. Armed Forces? 1Xiyes 2□No If Yes, Give Year or Dates:Korean 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 K No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Insurance Company 12 Years Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Schneider Pauline Kessler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15300 Pine Orchard Drive, Silver Spring, Maryland 20906 Delores H. Schneider - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/7/2008 Judean Mem. Gdns Olney, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Edward SAgel Funeral Direction, 1091 Rockville, Donald Maryland 20852 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease Minutes Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ypertension, Dementia, Protein Calorie Malnutrition, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Stage IV Sacral Ulcer, Spinal Stenosis with Paraparesis 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 XNursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 | Inpatient 2 ☐ ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Physician /Medical **Examiner** that the death certificate be executed and burial-tra P.O. Box 68760 attending physician the į the þ

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Examiner

Physician/Medical

Completed by

Be

Certification: To

29a. Certifier (Check only one)

Funeral

Director

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

with the Maryland

death v

hours after

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permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "ne any injury or other traumatic event, the Medic once.

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Maryland

signed t this After

Physician: or Attending after death filled in by hin 24 hours a the Funeral L Hospital

Vital Division or

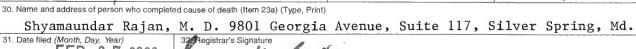
within ; To the

State Registrar

Shyamaundar Rajan, 31. Date filed (Month, Day, Year) 07 FEB

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29b. Signature and title of certifier



1 ☼ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D53367

29d. Date signed (Month, Dav. Year)

February 4, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Year Month **Physician** 4:00A Francis Willard Summers 6, Feb. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Tranquility of Fredericktowne Frederick Frederick 8. Date of Birth

A(Month, Day (Year))

Anr. 6, 1908 7. Age (In 99 9. Birthplace (State or Foreign Country) 5. Social Security Number (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex **Funeral** Days Hours Min **X** M 2 □ F 213-03-0458 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show MD Frederick Middletown 1 XYes 2 □ No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? a or death with 108 S. Jefferson St. 21769 USA 23a must Funeral permit. Pages 1 and 2 should be filed within 72 hours after dean Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ any injury or other traumatic events. 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White ð 3 XWidowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 clerk <u>hardware store</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Seymour Summers Annie Johnson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robin Zecker (Granddaughter)6 Wagon Shed Ln., Middletown, MD 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Risposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Lutheran cemetery 2/9/2008 Middletown, MD 5 Other (Specify) 4 □ Dopation re of un ral Arvice L Donald B. Thompson Funeral Home 31 E. Main St., Middletown, MD 21769 Approximate Interval Between Onset and Death or the disease, or complications that heart failure. List only one cause or sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immedia o use (Final disease or condition resulting in death) **Physician** months metastatic prostate cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an page certificate 2 **X**No 1∐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3 DOA 1 ☐ Inpatient ပ After this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attency within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifiei 1 🔾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

15

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32. Registrar's Signature

FEB 1 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Dr. Michael Behre, P. O. Box 17, Middletown, MD 21769

D16939

2/11/08

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| | | 1- For amend #8 Per FH G877 3/04/08 LH Certificate of Death Reg. No. | | | | | | | | | | | | | |
|--|--------------------|--|---|---|-----------------------------|----------------------------|-------------------------------|------------------------------------|-------------------------------|------------------------------------|---|---|--|--|--|
| Phy | sicia | | Decedent's Name (First, Middle, Last) John Thomas Sh | affer | | | | | | 2. Date of De Month | Day | | 3. Time of Death | | |
| /M | ledic | al - | 4a. Facility Name (If not institution, give s | | | | 4h City T | own, or Location | on of Death | 2 | 6 | 2008 County of Death | | | |
| Exa | min | er | Citizens Care & Re | | ion C | enter | | derick | on or 202 | | 1 | Frederic | | | |
| Fune | eral | | 5. Social Security Number 6. Sex | 7. Age | (In yrs. last | | If Under 1 | | der 24 Hrs. | 8. Date of Bir (Month, Da | | | nplace (State or Foreign | | |
| Direc | | | 5/8-42-5329 | M 2□F | 72 | Yrs. | MOTHE | Days | | FEB 6 | 1935 | Kno | xville, MD | | |
| and | -1 | - | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, T | own or Loc | ation | -, | | Mar 07,1935 | | | | | |
| Mary -feho | 180 | টু | MD Frederi | ck | Bru | nswic | k | | | | | | 1 ∰ Yes 2 □ No | | |
| h the | | Director | 10e. Street and Number | | | | 10f. Zip (| Code | | | 10g. Cit | 10g. Citizen of What Country? | | | |
| th wit | | a | 211 Delaware Avenu | ıe | | | | 21716 | | | | USA | | | |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiane. Important: If them 271 is marked or other than "naturel", or iteme 23a or 28a-1 ehow my Intrins or other transmissions. | EXECUTIVE IN | by Fur | 11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced | I2. Was Decedent E Armed Forces? 1 XYes 2 Notes If Yes, Give Year or Dates: | | i . | | int of Hispanic fy Cuban, Mexi | | cify Yes or No Rican, etc.) |)- | 14. Race - Amer Black, White Specify: | | | |
| 72 h | | etec | 15. Decedent's Educ (Specify only highest grade | | 1 | (Give F | kind of work | Occupation done during n | nost of workir | 16b. Kind of Business/Industry | | | | | |
| the. | e Me | Completed | Elementary/Secondary (0-12) | College (1-4or 5- | -) | | O NOT use | use Mai | 20202 | | | cht's Co shington | | | |
| Hygir a | n. | ပ္တို | 17. Father's Name (First, Middle, Last) | | | VV | areno | | | (First, Middle | | | i, Do | | |
| ld be lental | | To Be | Henry Herbert Shaf | fer | | | | Ida | a Eliza | abeth (| Care | y | | | |
| s man | E | | 19a. Informant's Name/Relationship (Type | | | | | | | | | City or Town, State, Zip Code) | | | |
| and 2 | | | Sharon Carey, Nied | e | | | | oe Driv | ve, Kn | oxv111e | e, MI | 21758 | | | |
| Definit. Pages 1 ar Depertment of Hee Important: If Item | ם סיר | | 20a. Method of Disposition 1 ☑Burial ∠ ☐ Cremation 3 ☐ R | emoval from State | ceme | etery, crem | sition (Name natory or oth | ner place) | ! | ate | 20c. Lo | ocation - City or 1 | Town, State | | |
| Pag tmen tant: | À I | | 4 □ Donaylog 5 □ Other (Specify) | 11/ | Brow | | | eights | | | | wnsville | e, MD | | |
| Depermit | Buch | | | liams, Ow | | 1 | 00 Pe | | lle Ro | ad, Bru | ınsw | e ick, MD | 21716 | | |
| Physici /Medic Examir | cal ner | ē | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a | consequen | ce of: | Liv | | as calciac o | Trespiratory a | - | | Approximate Interval Between Onset and Death | | |
| ifficate be executed g physicien and | ine burial-transit | ledical Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a | ı consequen | ice of): | | | | | | | | | |
| the death cert | ached for use as | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 | | | | | | | | 23d. Date of delivery Month Day Year | | | | |
| w requires that been signed by | 9 | ۾ | Part II. Other significant conditions con | tributing to death bu | t not resultin | ng in the un | derlying ca | use given in Pa | art I. | | | | the cause of death? | | |
| The The | 2 añad | Completed | | | | | | | | 24a. Was auto perfe 1 Yes | an psy primed? 20 No | prior to death? | topsy findings available completion of cause of 2 No | | |
| Physicien: The this certificate | 19010 | Be | 25. Was case referred to medical examiner? | ospital: | | | | - A | | (Check only | | | | | |
| - × v T | TUNBITAL OIL | tlon: To | 1 Yes 2 No 27. Manner of leath 1 Natural 5 Pending Accident Investigation | 1 Inpatier 28a. Date of Injury (Month, Day | / 28 | Outpatient Time of Injury | | c. Injury at Work? | 2 | ne 5 Resi | | 6 ☐Other (Spec ry occurred | ufy) | | |
| - 52 ± 3 | ad in by the | Certification: | 3 Suicide 6 Could not be determined | 28e. Place of Injubulding, etc. | ry - At home . (Specify) | , farm, stre | eet, factory, | | | 28f. Location (City or To | | | ral Route Number, | | |
| he Hospitel on 24 hours at the Funerel District filled in | pretery till | edical | 29a. Certifier (Check only one) Certifying Physical Examination (Check only one) | sician: To the best oner: On the basis of and manner state | examination | dge, death and/or inv | occurred a estigation, i | t the time, date in my opinion, | and place, a death occurre | and due to the ed at the time, | cause(s date and |) and manner as d place, and due | stated. to the cause(s) | | |
| To the To | uoo l | Ž | 29b. Signature and the of certifler | arfor | an | n |) 29c. | License numb | 997 | / | 29d. Da | te signed (Month | n, Day, Year) | | |
| 5 | | | 30. Name and address of person who co | | | | | | | | 1 | 1 | | | |
| | | | Robert L. Kaufmann | | | | h Str | eet, Fr | ederic | k, MD | 217 | 01 | | | |
| Rec | Stat gistra | | 31. Date filed (Month, Day, Year) | 32. Registra | Signature | K | 600 | De la | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For State Registrar | State | of Marylan | | artment of F rtificate of | | and M | | 21 | 200 | 05382 | |
|----------------------------|--|------------------|---|------------------------------|--|------------------------|---|-------------------|-----------------|---------------------------------|--------------------------------|---------------------------------|---------------------------------|--|
| | + | | Registrar 1. Decedent's Name (First, Midd | do Lasti | | Cei | illicate of | Dealli | | 2. Date of Dea | Reg. No. (| 000 | 3. Time of Death | |
| | Physici | an | Yvonne Grace | | | | | | | Februa | Day, | Year | 2:51AM | |
| | /Medic | ALCOHOL: | 4a. Facility Name (If not instituti | | number) | | 4b. City, Town, o | or Location o | of Death | 1 EDIUC | | 2008 ity of Death | 0.001. | |
| | Examin | er | Doctor's Comm | | | | La | nham | | | | - | eorge's | |
| Alternati | Funeral | | 5. Social Security Number | 6. Sex | 7. Age (In yrs. | last birthday) | If Under 1 Year Months Days | If Under 2 | 24 Hrs. Min. | 8. Date of Birt (Month, Day | h v. Year) | 9. Birthpl | ace (State or Foreign | |
| | Director | | 101-28-2636 | 1 □ M 2 🛣 F | 78 | Yrs. | Monard Bayo | 1100.0 | | July 9, | 1929 | | ssouri | |
| | and w | | Usual Residence of Decedent 10a. State 10b. Count | у | 10c. Cit | ty, Town or Lo | cation | | | | | 10 | 0d. Inside City Limits | |
| | Maryl f sho ied at | 힏 | Maryland Princ | e George' | s I | New Car | rollton | | | | | İ | 1X Yes 2 No | |
| | r 28a- | irec | 10e. Street and Number | | | | 10f. Zip Code | | | | 10g. Citizen o | f What Coun | try? | |
| | after death with the Maryland or items 23a or 28a-f show miner must be notified at | Funeral Director | 5806 Harland S | Street | | | 2 | | | USA | | | | |
| 1 | ems; | ner | 11. Marital Status | 12. Was De Armed I | cedent Ever in U | i.s. 13. | Was Decedent of I | Hispanic Original | gin? (Sp | ecify Yes or No Rican, etc.) | . 14. Ra | ace - America lack, White, e | | |
| | s after | | 1 Never Married 2 Ma | if Yes. (| s 2.2XNo Give | | 1 ☐ Yes 2 🔼 No | | | | | eify: Whi | te | |
| VONN 21215-003 | hours tural | Completed by | 3 Widowed 4 Divorce | d Year or ent's Education | Dates: | I 16a Dece | dent's Usual Occu | pation | | | 16b. Kind of Business/Industry | | | |
| 25. | in 72 n "nat n dedice | plet | (Specify only high | est grade completed | · | (Give | kind of work done DO NOT use retire | during mos | t of work | ing | | rsity | | |
| 722 | y within giene. | E | Elementary/Secondary (0-12) | College | (1-4or 5+) L | Se | cretary | | | | Mary | 1and | | |
| | be filed tal Hygi d other event, t | Be C | 17. Father's Name (First, Middle | e, Last) | | | | | | e (First, Middle, | | ame) | | |
| √ <u>la</u> | should b and Ment s marked umatic e | 은 | Donald R. Robe | erts | | | | L | | s Koeni | | | | |
| # \ Maryland | 2 sho | | 19a. Informant's Name/Relation | | - 1 1 | 1 | ng Address (Street | | | | | | , | |
| | 1 and leatth em 27 ther tr | | Robert Miller 20a. Method of Disposition | Smith - I | | | Harland | | | Date Carr | 20c. Location | | | |
| Saltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 1 Burial 2 ACremation | | m State I | | nsition (Name of matory or other pla | | | | | | | |
| ``∂≣ | artme artme ortani injun | | 4 Donation 5 Other (Specify) Metropolitan Crematory 2/8/2008 Alexandria, VA 22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20 | | | | | | | | | | | |
| Ba | permit. Departr Importa any inji | | Honste | | | | | | | | | | | |
| | 7 | | 23a. Part1. Enter the disease, shock, or heart failure. Li | or complications tha | t caused the deal | th. Do not en | er the mode of dy | ing, such as | cardiac | or respiratory a | rest, | | Approximate Interval Between | |
| | Physician | | Immediate Cause (Final disease or condition | at only one cause of | CANCE | =R | CUNG | | | | | | Onset and Death | |
| | /Medical | | resulting in death) | Due t | o (or as a consec | | | | | | | | | |
| - 65 | Examiner | | Sequentially list conditions, | b | | | | | | | | | | |
| | sit sit | Examiner | Sequentially list conditions, if any, leading to immediate course the fundamental course (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | | |
| | be executed ician and burial-transit | xan | | | | | | | | | | | | |
| 8760, | ficate be executed physician and s the burial-transit | dical E | | d | | | | | | | | | | |
| | ifficate g physi as the | edic | | 0. | | | | | | | | | | |
| Вох | th cer endin | J/UE | IF FEMALE: 23b. Was decedent pregnant | | outcome pf pregn | | ∃Ectopic pregnanc | ev | | | | Date of delive | • | |
| Э. | ed for | sici | in the past 12 months2 | | gnant at time of | | Other (specify) | | | | ' | Month | Day Year | |
| P.0 | requires that the death certificen signed by the attending I nould be detached for use as | Physician/Me | 9 ☐ Unknown Part II. Other significant condi | | | culting in the u | ndadvina cause ai | ven in Part I | | 23e Did t | obacco use co | ontribute to th | ne cause of death? | |
| Ś | ires the signer | by | rait ii. Other significant condi | tions contributing to | Geath Dut not res | sulting in the u | ridenying dadae gi | verriiri arri | | | | | ably 4 □Unknown | |
| Ö | w requires that been signed b should be deta | Completed | | | | | | | | 24a. Was | on 241 | h Wara auto | psy findings available | |
| æ | 10 2 0 | du | | | <u> </u> | | | | | auto | osy ormed? | prior to cor death? | inpletion of cause of | |
| <u>a</u> | | | 25. Was case referred to medic | eal | | | | 26 Place | of Doat | 1 Yes | 2 🔼 No | 1 🗆 Yes | 2□No | |
| ≒ | Physiclan: r this certific ral director, | To Be | examiner? 1 ☐ Yes 2 ☐ No | Hospital: | Ulapatient 2□ |] ER/Outpatie | nt 3 DOA Ot | her | | ome 5□Resi | | Other (Specif | γ) | |
| וס ר | ig Phys ter this neral dii | | 27. Manner of Death | /8.0 | te of Injury onth, Day Year) | 28b. Time o | f 28c. Inju | | | 28d. Describe | | | | |
| io | Attending I or death. ector: After by the funer | atio | Z LI Addidoni | tigation | | | M 1 | Yes 2 | No | | | | | |
| Division or Vital Records, | or Att | Certification: | 3 Suicide 6 Coul 4 Homicide dete | mined 28e. Pla | ce of injury - At h ilding, etc. (Speci | iome, farm, st ify) | reet, factory, office | | | 28f. Location (City or To | Street and Nui vn, State) | mber or Rura | I Route Number, | |
| Ω | pital c | | 200 Continue 45 Continue | ring Physician: To t | the best of my kn | owledge deal | h occurred at the | time date ar | nd place | and due to the | cauco(c) and | mannoraee | tated | |
| | B Hospital 24 hours a Funeral etely filled | Medical | | ai Examiner: On the | | | | | | | | | | |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Me | 29b. Signature and title of certif | | | | 29c. Licen | se number | | | 29d. Date sig | | Day, Year) | |
| | | | Dling | M | D | | no | 050 | 9= | 51 | 2/7 | 108 | | |
| | (10) | | 30. Name and address of person | | | | Print) | | | | | | | |
| N | | | REVA.S. 41 | 4 651 | O KE | NILL | DRIH | AVE | R | LIVER | DALE | MO | 20737 | |

31. Date filed (Month, Day, Year) FEB 0 8 2008

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Be Completed by

To L

Examiner

Physician

the burial-transit

page

| For State | | State | n waryian | and / Department of Health and Men Certificate of Death | | | | | | 2000 051 | | | | | |
|--|------------------|--------------------------------------|---------------------------------------|--|---|---------------------|---------------|------------|---------------------------------|-------------|---------------------------------------|--|--|--|--|
| Registrar 1. Decedent's Name | a (First Middle | 2 / ast) | | | lilicat | e oi i | Dealli | | 2. Date of Dea | Reg. No. | 200 | 3. Time of Death | | | |
| | - 01 | | | | | | | | Month | Day | Year | AM | | | |
| ETHEL SC | | D L n, give street and nu | ımher) | | 4h City | Town or | Location of | of Death | FEBRUAL | | 200 county of Dea | | | | |
| | | | | | | | | or Dodgii | | | | | | | |
| Social Security N | | EDICAL CE 6. Sex | 7. Age (In yrs. | | | | | | 8. Date of Birt | h | JNDEL Birthplace (State or Foreign | | | | |
| 142-01-2 | 517 | 1□M 2 X F | 90 | Yrs. | Months | Days | Hours | Min. | (Month, Da | | | ountry) W JERSEY | | | |
| Jsual Residence of | | | | | | | | | | | | | | | |
| 0a. State | 10b. County | | 10c. Cit | y, Town or L | ocation | | | | | | | 10d. Inside City Limits | | | |
| MARYLAND | QUEEN | ANNE'S | GRA | ASONVI | LLE | | | | | | | 1 ☐ Yes 2 💆 No | | | |
| 0e. Street and Nur | mber | | | | 10f. Zip | Code | | | | 10g. Citize | en of What C | ountry? | | | |
| PROSPEC | T BAY | DRIVE | | | | 21 | 638 | | | UNI | CED ST | ATES | | | |
| 1. Marital Status | | | cedent Ever in U. | .S. 13. | Was Dece | dent of H | ispanic Ori | gin? (Sp | ecify Yes or No Rican, etc.) | . 14 | I. Race - Am Black, Wh | erican Indian, | | | |
| 1 Never Marr | ied 2□ Marr | | 2 📉 No | İ | 1 ☐ Yes | | Specify: | i, i doito | Thour, oto., | | | HITE | | | |
| 3 Widowed | 4 ☐ Divorced | Year or I | Dates: | | 1 1 1 63 | 222110 | opedily. | | | | specify: | | | | |
| (Spec | 15. Deceden | t's Education st grade completed, | | (Give | edent's Usu e kind of wo | rk done o | durina mos | t of work | ing | 16b. Kind | of Busines | s/Industry | | | |
| Elementary/Seco | ondary (0-12) | College | (1-4or 5+) | life. | DO NOT u | se retired | 1) | | | | | | | | |
| 12 | | | | SECR | ETARY | | | | <i>(</i> =1 | | LISHIN | <u>G</u> | | | |
| 7. Father's Name | | | | | | | | | e (First, Middle, | | urname) | | | | |
| NICHOLAS | HATZD | OCK | | 1 | | | MAR | GARE | ET BALYO | | | | | | |
| 19a. Informant's Na | ame/Relations | hip (Type. Print) | | | - | | | | al Route Numb | | | | | | |
| PEG ANDA | HAZY/D | AUGHTER | | | | | Y DRI | VE, | GRASONV | TLLE, | , MARY | LAND 21638 | | | |
| 20a. Method of Disp | | 3 ☐Removal from | | Place of Disp cemetery, cre | osition (Na matory or o | me of other plac | ce) F | EBRU | JARY 8 | 20c. Loc | ation - City o | r Town, State | | | |
| 4 Donation | | | | LADY O | F LOURE | ES | | 2 | 800 | TRENI | ON, N | EW JERSEY | | | |
| 21. Signature of Fu | neral Service | Licensee |) | 2 | 2. Name a | nd Addres | ss of Facilit | BETN | AND NE | WNAM | FUNER | AL HOME, P.A | | | |
| 1/0 | () | 10 | <u>ر</u> | 1 | 06 SH | AMRO | CK RO | AD, | CHESTER | , MAI | RYLAND | 21619 | | | |
| 23a. Part1 Friter t | he disease, of | complications that only one cause on | caused the deat each line. | h. Do not er | ter the mod | de of dyin | ng, such as | cardiac | or respiratory a | rest, | | Approximate Interval Between | | | |
| Immediate Causedisease or condition | (Final | | Acit | b- 1 | 0,00 | CAP | 1.01 | 7 | WITARC | has | Ú | Onset and Death | | | |
| resulting in death) | | Due to | (or as a conseq | uence of): | 1010 | . 1 | Will | - | | 110 | | | | | |
| | | | CONO | EZT | UZ | th- | MET | F | -Alur | 1= | | | | | |
| Sequentially list co if any, leading to in cause. Enter Unde | nmediate | Due to | (or as a consed | uence of): | Λ | | , , , , | ^ | | | | | | | |
| Cause (Disease or that initiated events | injury | | CORO | NAN | in A | RTE | Ru | 1)1 | SEASO | | | | | | |
| esulting in death) | | Due to | (or as a conseq | uence of): | 1 | | | | | | | | | | |
| | | | | | | | V | | | | | | | | |
| | | - d. | | | | | | | | | | | | | |
| IF FEMALE: 23b. Was deceden | t pregnant | | tcome of pregna | | | | | | | 23 | 3d. Date of d | elivery | | | |
| in the past 12 1 ☐ Yes 2 [| months? | | birth 2□Feta nant at time of c | | □Ectopic p □ Other <i>(s_i</i> | | / | | | | Month | Day Year | | | |
| 9 ☐ Unknown | | 9□Unki | nown | | | | | | | | | | | | |
| art II. Other signi | ficant condition | ons contributing to | death but not res | ulting in the | underlying | cause give | en in Part I | | 23e. Did t | obacco us | e contribute | to the cause of death? | | | |
| H | VADER. | tousion | 0 | | | | | | 1 🗆 ' | res 2 | No 3□1 | Probably 4 ☐ Unknown | | | |
| 7 | 10:11 | (Lail | lates |) | | | - | | 04- 14/ | | 045 111-11 | | | | |
| | TKIMI | NDKI | MICH | | | | | | 24a. Was | | | autopsy findings available completion of cause of | | | |
| | | | | | | | | | 1∐ Yes | 2 No | 1 □ Ye | es 2□No | | | |
| | rred to medica | | | | | | 26. Place | of Deat | h (Check only o | ine) | | | | | |
| 25. Was case refer examiner? | / | | | | . / | | | | | | | | | | |
| examiner? 1 ☐ Yes 2 | No | Hospital: | Inpatient 2 | ER/Outpatie | | OA Oth | 4 □ NU | ursing Ho | ome 5□Resi | dence 6 | □Other (Sp | pecify) | | | |
| | No | Hospital: 1 | Inpatient 2 of Injury nth, Day Year) | ER/Outpatie | - | OA Oth | y at | ursing Ho | ome 5 Resident | | | ecify) | | | |

Medical Certification: To Be Completed by Physician/Medical in the past 1 1□Yes 2 9 Unknow Part II. Other sign

25. Was case reference 1 Yes 2 Manner of Dea 1 Natural
2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my oninion, death occurred at the first data. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICIA BOWYER MD MPH 115 SA PATRICIA

31. Date filed (Month, Day, Year) - 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 31, 2008 1:35 A^{M} January Albert Simons /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Laurel Regional Hospital Prince George's Laurel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2 ☐ F Director 577-22-3177 88 1919 South Carolina Sept. 6. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State notified at 1 XYes 2 No Director Prince George's Bowie 28a-f Maryland | 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō Examiner must be items 23a 20715 USA 13014 Midsummer Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X**) No Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2X No þ Specify: 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry r than Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Safeway other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H Item 27 is marked oth r other traumatic even Be Walter Simons Alice Simons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13014 Midsummer Lane Bowie, MD 20715 Jane E. Simons/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of H Important: If ite any injury or of 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2/4/2008 4 ☐ Donation 5 ☐ Other (Specify) Rockville, MD Parklawn Cemetery 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 2 Days disease or condition resulting in death) Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 □Ectopic pregnancy Month in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 TUnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u></u> Chronic Lymphocytic Leukemia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2X No this certific al director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No 1X Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 🛛 Natural 2 Accident

Division or Vital Records, P.O. Box 68760. Director:

5 ☐ Pending investigation

6 □ Could not be determined

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Discretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

29c. License number D24721

29d. Date signed (Month, Day, Year)

1/31/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Syed Sadiq, M.D. 14333 Laurel Bowie Road #208 Laurel, MD 20708

31. Date filed (Month, Day, Year) State Registrar FEB 0 6 2008

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

Registrar's Signature

hin 24 hours aft the Funeral Di mpletely filled in

2

Medical

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12-08 Year 120 PM **Physician** TER /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** SIEN 303 5.W 51. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** 38X 162 M 2□ F Days 216-12-6240 Usual Residence of Decedent Yrs Director 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location or 28a-f ahow other traumatic avant, the Medical Examiner must be notified at 1 Yes 2 W Completed by Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 303 5 · A 238 Pages 1 and 2 should be filed within 72 hours after death vinent of Health and Mental Hygiene. ant: If item 27 Is markad other than "natural", or items 23s 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1944-46 Specify 3 Widowed 4 □ Divorced JAITE 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DRIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARY E. KANANAURH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 303 A ST. S. W GENBLANIE, MO - ZIOGI 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. DENT CREMATORY * 4 ☐ Donation 5 ☐ Other (Specify) e and Address of Facility 21. Signature Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD. 21122 of enter the mode of dying, such as cardiac or respiratory arrest, Part1. Enter the disease, or complications that caused the des Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The taw requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of): IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the a detached Š 23e. Did tobacco use contribute to the cause of death? Part [I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records, funeral director, page 2 should be 1 🗀 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 10) (21 24a. Was an autopsy 2 **V** No 1 Yes Yes 25. Was case referred to 11 edical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 dence 6 Other (Specify) Certification: To 1 🗌 Yes 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 🗌 Yes 2 □ No death. 2 Accident Diractor: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 | Homicide within 24 hours a To the Funeral C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day, Year) 2 2008

32 Registrar's Signal e

(Item 23a) (Type,

TURNER

waster

1 Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month.

Dav. Year)

0

| | | • | For State Registrar | State of Ma | ai yiai iu | | tificate of | | u menta | Reg. 1 | Z U U | 18 | 0538 | 3 / |
|---|--|----------------|---|--|-------------------------------|--------------------------------|---|--------------------------|-------------------------------|-----------------------------------|-----------------------|--------------------|---|-----------|
| | Physicia | an | Decedent's Name (First, Middle, La | st) | | 7 . | | - | 2. Date | e of Death | Day Y | /ear | 3. Time of De | ath |
| | /Medic | al | 4a. Facility Name (If not institution, giv | an Mi | 100 | 1 | 4b. City, Town, o | or Location of De | eath | 2 | 4c. County of | Death | 1BC | <u> </u> |
| | Examin Funeral Director | er | 5. Social Security Number 6.5 | Hospita | 000 je (In yrs. Ia 78 | st birthday) _ Yrs. | If Under 1 Year Months Days | ord to | Hrs. 8. Date | e of Birth onth, Day, Yeary 30, | 8+.1° | Man | is | oreign |
| D | ~ | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City. | Town or Loc | ation | | | | | | I. Inside City L | imits |
| Maryla | f shov led at | JO. | | fary's | Too. Oity, | 10111101 200 | | ington | Park | | | | 1 □ Yes 2 | |
| h the | r 28a- | Director | 10e, Street and Number | | 1 | | 10f. Zip Code | 2118 | Talk | 10g. | Citizen of Wh | at Country | /? | |
| ath wit | 23a c ust be | ralD | 21577 South Esse | | | | | 20653 | | | US. | | Indian | |
| 2 should be filed within 72 hours after death with the Maryland | Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral | 11. Marital Status 1 □ Never Married 2 Amarried 3 □ Widowed 4 □ Divorced | 12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔀 I If Yes, Give Year or Dates: | | | Vas Decedent of N Yes, specify Cub ☐ Yes 2X No | | ? (Specify Ye uerto Rican, | etc.) | 14. Race Black, | White, etc | c. | |
| 72 hou | natura Jical E | | 15. Decedent's E (Specify only highest gra | ducation ade completed) | | 16a. Deced | ent's Usual Occu kind of work done O NOT use retire | pation during most of | working | 16b | . Kind of Busi | iness/Indu | stry | |
| within | than " | Completed | Elementary/Secondary (0-12) | College (1-4or 5 | 5+) | | aft Mech | | | | US Go | vernm | ent | |
| pe filed | d other | Be | 17. Father's Name (First, Middle, Last | | | | | 18. Mother's | | | |) | | |
| hould I | d Men marker matic e | ဥ | Oscar Harvey Ulri | | | 19b Mailin | a Address (Stree | | | leinem: Number Cit | | tate. Zip C | Code) | |
| and 2 s | alth an 27 Is r r traur | | Hazel Lorene Ulri | | | | South E | | | | | | D 2065 | 3 |
| Pages 1 a | nent of Hea int: If Item iry or othe | | 20a. Method of Disposition 1 Burial 2 ACremation 3 E 4 Donation 5 Other (Speci | Removal from State | | ace of Dispos emetery, cren | sition (Name of natory or other pla n Cremator | reb | Date oruary 1 2008 | 20c | Location - C | ity or Tow | n, State | |
| permit. | Departr Importa any Inju | | 21. Signature of Funeral Service Lice | Harden | ev | | Name and Addr Mattingle P.O. Box | y-Gardine 270 Leon | r Funer ardtown | al Home | P.A. 20650 | | | |
| Pŀ | ıysician | | 23a. Part . Enter the disease, or on shick, or heart failure. List only immediate Cause (Final disease or condition | ppli ations that caused one cause on each li | d the death. ne. 1RA [5 | . Do not ente | FAIWKE | ing, such as car | rdiac or respi | ratory arrest, | | 1 | Approximate nterval Betweet Onset and Dea | en ath |
| | Medical xaminer | | resulting in death) | Due to (or as | a conseque | ence of): 7A71C | FAILURE | -e_ | | | | ĺ | VEFF | 5 |
| pe | sit | iner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as | | ence of): | (ER | | | | | 7 | EARS | |
| tificate be executed | ig physician and as the burial-transit | cal Examiner | that initiated events resulting in death) Last | CDue to (or as | | | | | | | | | | |
| rtificat | ng phy as the | Medical | IF FEMALE: | | | | | | | | | | | |
| he death ce | within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use | Physician/N | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown | 2 Fetal | death 3 | Ectopic pregnand Other (specify) _ | су | | | 23d. Date Mon | of deliver th [| y Day Yea | ar |
| uires that | signed by d be deta | by | Part II. Other significant conditions | contributing to death b | out not resu | Iting in the ur | nderlying cause g | iven in Part I. | 23 | | | | cause of dea | |
| iw regi | s been shoul | Completed | | | | | | | 24 | la. Was an | 24b. W | /ere autop | sy findings av | ailable |
| The la | ite has | omo | | | | | | | 1[| autopsy performed ☐ Yes 2 □ | 1? de | eath? | pletion of cau: 2□ No | se or |
| cian: | ertifica | BeC | 25. Was case referred to medical examiner? | 14-24-1 | | | | | Death (Chec | ck only one) | | | | |
| Physic | this or | 은 | 1 ☐ Yes 2 ☑ No 27. Manner of Death | Hospital: 1 Inpati | | ER/Outpatien 28b. Time of | 1 3 DOA | | | | e 6 DOthe | |) | |
| ding | th. ; After ; funer | tion | 1 Natural 5 Pending 2 Accident investigation | (Month, Da | ay Year) | Injury | Wo | ork? ∐Yes 2∐No | | | ,, | | | |
| lor Atter | after dea I Director d in by the | Certification: | 3 Suicide 6 Could not to determined | Zoe. Place of In | jury - At hol tc. (Specify | me, farm, str | eet, factory, office | 9 | 28f. Lo | cation (Stree ty or Town, S | t and Numbe State) | er or Rural | Route Numbe | ∍r, |
| e Hospita | within 24 hours afte To the Funeral Dir completely filled in | Medical C | | hysician: To the best miner: On the basis of and manner s | of examinat | | | | | | | | | |
| Toth | To the | Me | 29b. Signature and title of certifier | | | MD | | nse number | | | Date signed | | Day, Year) | |
| 6 | | | 1 Ky Ch | | | | | D56076 | | | ユーハー | 08 | | |
| 2 | 10 | | 30. Name and address of person who | Completed cause of | death (Item | 23a) (Type, | Print) SOCIA TE | -5 , 11 | cilyu | 1000 | MD | 2 | 0636 | |
| | Sta | | 31. Date filed (Month, Day, Year) | 9 | rar's Signat | | | | | | | | | |

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

| | | | 1 - State Registrar | Otate of Maryla | | rtificate of | | R | eg. No. | 108 | 0538 | | | |
|---------------|---|----------------|---|---|---|--|---------------------|--|-------------------|---|---------------------------------------|--|--|--|
| | Physici | an | 1. Decedent's Name (First, Middle, Las Diana K. Vine | , | | | | 2. Date of Deat Month | Day 2008 | Year | Time of Death | | | |
| | /Medio | | 4a. Facility Name (If not institution, give | | | 4b. City. Town. | or Location of Dea | Feb. 6, | 4c. County | | 38 P ^M | | | |
| | E X d I I I I | iei | 905 Pleasant Hill | | | Bov | | | | ce Geor | rae's | | | |
| | Funeral Director | | 130-20-0307 | 7. Age (In yrs | . last birthday) Yrs. | If Under 1 Year Months Days | | | | | (State or Foreign | | | |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | 10c. C | ity, Town or Lo | cation | | | | 10d Jr | nside City Limits | | | |
| | Maryli -f sho ied al | tor | | _ | Sowie | | | | | | Yes 2⊠No | | | |
| | n 188a r 28a notif | Director | MD Prince G | eorge s | 01110 | 10f. Zip Code | | 1 | 0g. Citizen of W | hat Country? | | | | |
| | 23a c | alD | 905 Pleasant Hil | l Lane | | 207 | 716 | | USA | | | | | |
| 36 | filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 □ Never Married 2 ※ Married 3 □ Widowed 4 □ Divorced | 12. Was Decedent Ever in I Armed Forces? 1 Tyes 2000 If Yes, Give Year or Dates: | | Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 X No | | Specify Yes or No- rto Rican, etc.) | | - American In K, White, etc. | | | | |
| 2-0036 | 2 hour atural cal Ex | ed t | 15. Decedent's Edi | acation | 16a. Deced | dent's Usual Occu | pation | 1 | 16b. Kind of Bu | Whit siness/Industr | | | | |
| 215 | hin 72 9. an "na Medio | Be Completed | (Specify only highest grade Elementary/Secondary (0-12) | de completed) College (1-4or 5+) | (Give life. I | kind of work done DO NOT use retire | during most of wed) | orking | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | , | | | |
| 2 | ygiener the | Com | | 4 | Regi | istered N | Jurse | | _V.A. F | Mospita | .1 | | | |
| Maryland | be mital eve | Be | 17. Father's Name (First, Middle, Last) | | | | | ame (First, Middle, M | | 9) | | | | |
| $\frac{2}{5}$ | should be and Mental s marked o umatic eve | ဥ | Peter Dukovic 19a. Informant's Name/Relationship (T | Lorkovcich | COVCLCD Coute Number, City or Town, State, Zip Code) | | | | | | | | | |
| <u>8</u> | s 1 and 2 should F Health and Mer tem 27 is marke other traumatic | | Richard A. Viner | | 905 I | Pleasant | Hill Lar | ne Bowie, | MD 20 |)716 | e) | | | |
| Baltimore, | m 0 | | 20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3 ☐ | 20b. | Place of Dispo cemetery, crer | sition (Name of matory or other pla | rce) Fek | Date 11, | 20c. Location - (| City or Town, S | State | | | |
| | permit. Page Department Important: If any injury or once. | | 4 □ Donation 5 □ Other (Specify) | 1 | - | itan Crem | ı. 20 | 008 7 | Alexandr | | | | | |
| g | perm Depa Impo any i | | 21. Signature of Funeral Service Licens | 21/1 | 22 | 2. Name and Address 6512 NW | | Beall Fu vy. Bowie | | iome 1715 | | | | |
| 24. | Physician | 9r | 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death | | | | | | | | | | | |
| | /Medical | | resulting in death) | a Due to (or as a conse | quence of): | 1 | 7 | 7777.700 | | | 0 | | | |
| | Examiner | | Sequentially list conditions | b. 150 | henre | yofath | my yis | | | | | | | |
| | uted Insit | Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conse | Harana | alem 6 | | ad min | - lus | ' | 1100 | | | |
| ے ت | exection and and rial-tra | | that initiated events resulting in death) Last | Due to (or as a conse | quence of): | 010-01 | di | sinse | ucy c | | 7. | | | |
| 08/PN | rificate be executed Ig physician and as the burial-transit | Medical | | d | | | | | | | | | | |
| . B 0X | death cei e attendir d for use | Physician/Mec | in the past 12 months? 1 Yes 2 No | 23c. If yes, outcome pf pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown | al death 3 | Ectopic pregnanc Other (specify) | у | | 23d. Date Mor | of delivery of Day | Year | | | |
| r Ö | hat the | Phy | 9 ☐ Unknown Part II. Other significant conditions co | | culting in the ur | oderlying cause giv | en in Bart I | 23a Did toh | acco use contri | huta ta tha sa | use of death? | | | |
| cords, | law requires that the de as been signed by the 2 should be detached | ρ | | nic read | | ilure | | | | | 4 Wunknown | | | |
| ပ္ပ | 2 33 2 | Completed | cen | emia | | | | 24a. Was ar | | /ere autopsy fi | indings available tion of cause of | | | |
| <u>r</u> | ate pag | Com | | | | perform | ned2 d | eath? □Yes 2 | | | | | | |
| VITAIL | Physician; The this certificate rai director, pag | Be | 25. Was case referred to medical examiner? | Hospital: | | l Ou | | eath Check onl one | 9 | | | | | |
| 0 | Phys this al dii | 7 | 1 ☐ Yes 2 No 27. Manner of Death | 1 ☐ Inpatient 2 ☐ 28a. Date of Injury | ER/Outpatien 28b. Time of | C OLI DON | | Home 5 Reside | | | | | | |
| | Attending F r death. ector: After by the funera | tion | 1 Natural 5 Pending 2 Accident investigation | rk? Yes 2∐No | 28d. Describe how injury occurred | | | | | | | | | |
| DIVISION | al or Attend s after death. Il Director: v d in by the f | Certification: | 3 Suicide 6 Could not be 4 Homicide determined | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer | Medical C | (Check only 2 Medical Exam | sician: To the best of my kn iner: On the basis of examin and manner stated. | ation and/or inv | vestigation, in my | opinion, death occ | curred at the time, d | ate and place, a | nd due to the | cause(s) | | | |
| | To t To t | Ź | 29b. Signature and title of certifler Lound Cd, 30. Name and address of person who co David A. Boet | Hending P | Myslein | 29c. Licens | se number | 29 | od. Date signed | (Month, Day, | Year) | | | |
| 0 | (10) | | 30. Name and address of person who co | ampleted source of death " | , MI, U, | Print) | | | ren, o | 1 200 | 20110 | | | |
| 1 | (00) | | David A Boel | chev M.D. | 1430 0 | Gallan | + Fox | have the | 8, Bo | wie, | MD | | | |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32. Registrar's Sign | ature | | | | <u> </u> | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

| mothy Vaughn | | State of Maryland / Department of -For State Certificate of | | giene Reg. I | 200 | 8 05389 | | | | | |
|--|----------------|---|--|--|-------------------------------------|--|--|--|--|--|--|
| Physician ledical Examine | 1 | legistrar 1. Decedent's Name (First, Middle,Last) Timothy Jayden Vaughn | | 2. Date of Death Month Da February 14, | ay Year 2008 | 3. Time of Death 0802 hrs | | | | | |
| / | | 4a. Facility Name (if not institution, give street and number) 4 | b. City, Town, or Location of Death | T CDT daily 1 1, | 4c. County of Death Anne Arundel | | | | | | |
| Funeral | | Anne Arundel Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | Annapolis If Under 1 Year If Under 24Hrs. | 8. Date of Birth(| MM/DD/YYYY) 9. Birt | | | | | | |
| Director | | 220-79-4608 XXM 2 F Yrs. | Months Days Hours Min. | 11/19/2 | Poreig 2007 | n untry) MD | | | | | |
| any | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | on | | | 10d. Inside City Limits | | | | | |
| | <u>.</u> | | 1 Yes 2 X No | | | | | | | | |
| Maryla or 28a-f | Director | 10e. Street and Number 1261 Collins Ave. | 10f. Zip Code 21113 | 10g. | Citizen of What Court USA | ntry? | | | | | |
| | | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was | l s Decedent of Hispanic Origin? (Sp | | | ican Indian, Black, | | | | | |
| r death | Funeral | 1 X Never Married 2 Married 1 Yes 2 X No | es, specify Cuban, Mexican, Puerto l Yes 2X No specify: | Rican, etc.) | | hite | | | | | |
| urs afte | 함 | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent | t's Usual Occupation (Give kind of woost of working life. DO NOT use retir | | 6b. Kind of Business/ | | | | | | |
| 56 n 72 ho nan "na lie I Ex | Completed | Elementary/Secondary (0-12) College (1-4 or 5+) N/A | ost of working life. DO NOT use retir | ea) | N/A | | | | | | |
| 21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medie | | 17. Father's Name (First, Middle, Last) | 18.Mother's Name | | den Surname) | | | | | | |
| 1215 d be file lental H arked event, t | å | Thomas R.O. Vaughn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing | Jennife Address (Street and Number or R | er B. Don | - | e. Zip Code) | | | | | |
| MD 2 d 2 shoul lith and M n 27 is m aumatic | 2 | Jennifer B. Dorey Mother 1261 | Collins Ave. Ode | enton, M | 21113 | | | | | | |
| re, h | | 4 V Buriel 2 Cremetics 2 Removed from State crematory or oth | | | 20c. Location - City of | | | | | | |
| Baltimore, permit. Pages I a Department of He Important: If ite injury or other tr | - | Our Lady of the Fields 2/20/2008 Millersville 1 Donation 5 Other Specify: 21. Spinature of Funeral Service Licensee 22. Name and Address of FacilityHardesty Funeral Home, 1 | | | | | | | | | |
| Bal permi Depar Impo injur | | Van Man 12 | Ridgely Ave. And | napolis, | MD 21401 | | | | | | |
| Physician Medical | | 3 Part I. Enter the disease or complications that caused the death. Do not enter the failure. List only one cause on each line. | | r respiratory arresi | t, shock, or heart | Approximate Interval Between Onset and Death | | | | | |
| caminer | | Immediate Cause (Final disease condition resulting in death) a. Sudden Unex lain 1 beth in Infancy Due to (or as a consequence of): | | | | | | | | | |
| | ے ا | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of): | | _ | | | | | | | |
| | Examine | Cause. Enter Underlying Cause (Disease or injury that initiated c. | | | | | | | | | |
| executed an and al - transit | | events resulting in death) Last Due to (or as a consequence of). d. | | | | | | | | | |
| sicial sicial . | edical | X UNPENDED AMENDED 23a,27,28a-f per M | 1E g878 4/28/08 amh | | 23d. Date of delive | D. | | | | | |
| Box 68760, redeath certificate be earthe attending physician ned for use as the burial | | naet 12 months? | etal death 3 Ectopic pregna | ancy | Month Month | Day Year | | | | | |
| Sox 6 death ce attend for use | Physician/M | 1 Yes 2 No 9 Unknown Pregnant at time of death 5 Of | ther (Specify) | | | | | | | | |
| ্ৰ কুর । | b P | Part II. Other significant conditions contributing to death but not resulting in the | underlying cause given in Part I. | | acco use contribute t | o the cause of death? | | | | | |
| ords, P.C. aw requires that has been signed 1 2 should be deta | | | | 24a. Was ar | 24b. Were a | autopsy findings available | | | | | |
| corc e law re e has be | Completed | | | autops perform 1 ✓ Yes 2 | ned? death? | | | | | | |
| Division of Vital Records, tal or Attending Physician: The law requinrs after death. The Director: After this certificate has been so led in by the funeral director, page 2 should be an early or the funeral director, page 2 should be a should be | ္မရ | 25. Was case referred to medical | 26.Place of Death (Check | only one) | | | | | | | |
| f Vita Physici er this o | 위 | examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatien 27. Manner of Death 28a. Date of Injury 28b. Time of | | | tesidence 6 Oth | er: | | | | | |
| on of ending Pl ath. or: After the funera | ţion | 1 Natural 5 Pending Ible | 1 Yes 2 X No | Unik | | | | | | | |
| IVISI or Attr after de Directo | Certification: | 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, stre | eet, factory, office building, etc. | 28f. Location (St or Town, Sta | | Rural Route Number, City | | | | | |
| Divis Hospital or A 24 hours after Funeral Dire | | 29a. Certifier Certifying Physician: To the best of my knowledge death occur | irred at the time, date and place, and | Unk due to the cause | (s) and manner as st | ated. | | | | | |
| To the Hos within 24 h To the Fur | Medical | one) 2 Medical Examiner:On the basis of examination and/or investigation and manner stated. | ation, in my opinion, death occurred | at the time, date a | and place, and due to the cause(s) | | | | | | |
| | Σ | 29b, Signature and title of certifier | 29c. License number O.C.M.E. | | 29d. Date signed (MFebruary 15, 20 | | | | | | |
| | | 30. Name and address of person who completed cause of death (Item 23a) | | | | | | | | | |
| | | Laron Locke MD. Assistant Medical Examiner 111 Pen | n Street, Baltimore, MD 212 | 201 | | | | | | | |
| Sta Registr | | 31. Date filed (Month, Day, Year) FEB 1 9 2008 32. egistrar's Signature | ense | | | | | | | | |
| DHMH 17 Rev 1/20 | | DCME ORIGINA | AL | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** : 00 PM Wallace INSCO 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Prince Frederick 15 Arthur King Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours 1 X M 2 □ F Director 91 Maryland May 15, 1916 217-05-1207 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Calvert Prince Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20678 Funeral 15 Arthur King Road 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any Injury or other traument. 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify. 2 3 Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction 5 Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hattie Commodore ဥ John Cephas Wallace 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Arthur King Road, Prince Frederick, MD 20678 Shelia Tyler - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Solid Rock Church Cemetery: 2/9/2008 Port Republic, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility evely Made Sewell Funeral Home, PA, 1451 Dares Beach Rd., Prince Frederick, MD 2067 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UNKNOWN 3 months **Physician** metrotatic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in its lead of the cause). Due to (or as a consequence of): Examine physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical as sate has been signed by the attending I page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1∐ Yes 2 No 1 Tyes after death.

I Director: After this certifice funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 X Natural М 1 Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of & 110 HOSPITAL RO PAFAEOGREE MD who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe CHARLES 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar 2008 Moult,

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Sarah E. Washington 2:10 P. February 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Southern Maryland Hospital Center Clinton Prince George's Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day. Days Hours 1 □ M 2√2 F 577-24-9234 91 February 17. 1916 Washington, D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Maryland Prince George's Fort Washington 1√√Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 802 Sero Pine Lane 20744 U.S.A. Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 💢 No Specify. Specify: Black þ 3 M Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Department Of Agriculture Key Punch Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Short Robert Butler ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zin Code) 802 Serro Pine Lane Fort Washington, Maryland 20744 19a. Informant's Name/Relationship (Type. Print) Patricia Am Bonds (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State February 13, 2008 Clinton, Maryland Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. In 23a. Part Enter the disease, or complications that caused the sath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) In know Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 dunknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a, Was an performed? res 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 240 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Yes 2 No 2 Accident

Examiner requires that the death certificate be executed burial-trar Box 68760, physician the as for use P.0. the a signed by t Division or Vital Records,

Examine Physician/Medical þ Completed page 2 should certificate has Be After this funeral Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director, After filled in by

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be

permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygic Important: If item 27 is marked other 1 any injury or other traumatic event, th

Physician

/Medical

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

State Registrar

Medical

29b. Signature and title of certifie

6 ☐ Could not be

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

FEB 11

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name And acties of a recom

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death Decedent's Name (First, Middle, Last) Year Physician 11:03 P Williams, Jr. February 4. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 ☐ F Director 141-16-6875 Oct. 17, 1925 82 Florida Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County i Heelth and Mental Hygiene. Itam 27 is marked other than "natural", or items 23a or 28a-1 ehov other treumatic event, the Madical Examinar must be notified at 1 Yes 2 □ No Maryland Montgomery Silver Spring Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 901 Arcola Avenue 20902 United States death Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify: Specify: by 3 Nidowed 4 □ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Self Employed <u>Businessman</u> permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Importent: if Item 27 is marked othen eny lighty or other treumatic event, 908. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Roger Williams Ruth Mann ۴ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gary Williams - Son 3800 Fairfax Drive Arlington, VA 22203 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Crownsville Vet. Cemt. Feb. 11, 2008 Crownsville, MD Azz. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sig neral Service Lice 1001 Benning Road, NE Washington, DC 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** 5 Days Bilateral Pneumonia /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading of immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner or Attending Physician: The law requires thet the death certificate be executed and resulting in death) Last Due to (or as a consequence of) Box 68760. by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Year detached for Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No P.0. 9□ Unknown 9 Ulnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 🛣 No 3 ☐ Probably 4 ☐ Unknown Acute Renal Failure, Sick Sinus Syndrome, Hypertension, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? Cardiomyopathy, Ventricular Tachycardia: Nonsustained autopsy performed? 1 ☐ Yes 2 ☐ No certificete 2 📆 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 👿 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 ☐ No 3□ DOA 2 ER/Outpatient this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Medical 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 5, 2008 D53367 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Georgia Ave. #117 Silver Spring, MD 20912 9801 Shyamsundar Rajan, M.D.31. Date filed (Month, Day, Year) 32. Registrar's Signat State 1 2008 Registrar FEB 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 7, 2008 Month **Physician** John Phillip Wallace February 3:20 P. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Villa Rosa Nursing Home Mitchellville Prince George's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1**½** M 2□ F Davs Hours Min 67 Director 11/11/40 Halifax Co., N.C 242-54-5209 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "naturai", or items 23a or 28a-f show dical Examiner must be notified at 1 XYes 2 □ No Director Md. Prince George's Lanham 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 10009 Ellard Drive 20706 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Black Specify: 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 9th College (1-4or 5+) other than Truck Driver Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Lacey Wallace Florence Hunt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. Gloria A. Gaskins/Daughter 10009 Ellard Drive, Lanham, Maryland 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cem. 02/16/08 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee Xauu 23a. Part1. Inter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SPIRAT Immediate Cause (Final disease or condition resulting in death) **Physician** OAHS /Medical Due to (or as a consequence of): Examiner Rogrescive 5 Upn Bruchen if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of) physician a s the burial-Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 s autopsy performed? 1□ Yes 2 No page death? 1 ☐ Yes certificate 2□ No or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: / 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 152261 02-08-2008

Registrar

-0(1 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 1 1 2008

completed cause of death (Item 23a) (Type, Print)

30. Name and address of person who

5.6

AMAROLII SL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav **Physician** 4 2008 2:09 Mildred Theresa Washington February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince George's Washington, Mildred If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Min. Months 1 M 2 TF Hours 65 Director 213-40-5596 03/10/42 Wash., D.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show notified at Yes 2□No Director Md. P.G. District Heights .28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or the M-dical Examiner must be 6705 Atwood St. # 1 20747 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married African-Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Specify. þ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Management/ Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien. Important: If Item 27 is marked other than any Injury or other traumatic average. 11th Resident Manager Apartment Complex 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Edward Washington Louise Spriggs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pauline E. Washington/Sister 4238 Suitland Rd.#103 Suitland, Md. 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State W Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Resurrection Cem. 02/12/08 Clinton, Maryland 22. Name and Address of Tacility of the Sons Co., Inc. 21. Signature of Funeral Service Licensee any W. s 1 RU 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Breast Concer /Medical Due to (or as a consequence of): Examiner all Renal Concer Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to for as a consequence of): Examiner requires that the death certificate be executed Jesti comu physician and s the burial-tran Due to (or as a consequence of): Box 68760 Hyper tension Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2 ₺No Day 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy death? 1 ☐ Yes 2 ☐ No performed' 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 5 ☐ Pending Investigation Injury 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 ho

To the Fune (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00059981 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LANDOUZE ROAD SUITE 3 CHEVELLY, MO 20185 N.S.

DHMH 17 Bev 1/2001

State Registrar

DHMH 17 Rev 1/200

Registrar

08-00876 James Edward White

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| 2 | 0 | 0 | 8 | 0 | D | 3 | 9 | 1 |
|---|---|---|---|---|---|---|---|---|
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| | | | | For State | | • | (| Certific | cate of | Death | | | | | Reg. No | Lon | | | |
|-------|--|---|---|--|-------------|---------------|----------------------------|-------------------------|--|-----------------------------|-----------------------|-------------------------|----------|------------------|----------------------|---------------------------------------|---------------------------------|-------------------------------|-------------|
| | Physicia | an/ | | gistrar Decedent's Name (First, N | iddle,Last |) | | | | | | | | Date of Month | Dav | Year | | Time of Deat 1531 hrs | n |
| #Cas | ∼l Exami | | r | James Edward White | | | | | | | | | | January 31, 2008 | | | | | |
| | | | 48 | a. Facility Name (if not insti | ution, give | street and n | umber) | | 41 | o. City, Tov | | | | | | Charles | Deam | | |
| | | | | 15180 Deborah Dr | ve | | | | | Californ | | lughes | ville | 2 Date | | | a Rieth | place (State or | |
| | Funeral | | 5. | Social Security Numbar | 6. Se | х | 7. Age (In | yrs. last b | oirthday) | If Under Months | 1 Year Days | If Under 2 Hours | Min. | | | | Foreign | | |
| | Director | | | 217-96-9192 | 1100 | M 2 F | 41 | L | Yrs. | Months | Days | 110013 | 194111. | 09/ | 11/1 | 966 | Cour | Maryl Maryl | and |
| | _ | l | _ | sual Residence of Deceder | | | | | | | | | | | | | | 10d. Inside Cit | v Limits |
| | any | | 10 | 10a. State 10b. County 10c. City, Town or Location | | | | | | | | | | | | - | | | |
| | d how | ١. | _ | MD Cha | r1es | | | Hugh | esvil | 1e | | | | | | | | | |
| | A should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show any matic event, the Medical Examiner must be notified at once. | 1 5 | 3 1 | De. Street and Number | 1100 | | | | | 10f. Zip C | Code | | | | " | itizen of Wh | at Count | ry? | |
| | or 28 | Director | <u> </u> | 15180 Deborah Drive | | | | | | 20 | 637 | | | | 1 | JS | | | |
| | ith th 23a noti | 7 | | Marital Status | | | ecedent Eve | r in U.S. | 13. Was | Deceden | t of Hisp | anic Origin | n? (Spec | cify Yes | or No- | | - America | an Indian, Blac | ck, |
| | ath w | Funeral | <u> </u> | Never Married 2 | Married | F | Forces? | No | If Ye | es, specify | Cuban, | Mexican, I | -ueno R | ican, etc | .) | 1 | 5, 010. | | |
| | or de | ļū | | 3 Widowed 4 | Divorced | 1 Yes | | | | Yes 2 | | specify: | | | | Specify: | Whi | | |
| | hours afte 'natural'', Examiner | 2 | ? - | 15. Decedent's Education | | | | led) 16 | a. Deceden | t's Usual O | ccupatio | on (Give ki | nd of wo | rk done | 16b | . Kind of Bu | isiness/In | dustry | |
| | 2 hours al "natural I Examin | Poto | į | Elementary/Secondary (0 | | | (1-4 or 5+) | | during me | ost of work | ing life. | DO NOT U | Se reme | u) | | | | | - |
| 20 | hin 72 thau thau edical | | | 12 | | | | | O | wner | /Ope | rator | | | | ildli | fe M | anagem | ent |
| 50036 | led within 72 Hygiene. other than ' | 8 | ξŀτ | 7. Father's Name (First, M | ddle, Last |) | | | | | 1 | | | | | en Surname |) | | |
| 745 | uld be filed within Mental Hygiene, marked other the Cevent, the Med | | 2 | Francis Ed | | | : | | | | | Joy | Ela | ine | Kro1 | 1 | 01-1- | 7:- C-d-) | |
| Š | ould be fill Mental F marked ic event, I | 1 6 | 2 1 | 9a. Informant's Name/Rela | | | | | 19b. Mailing | | | | | | | | | | |
| 2 | and 2 shoul lealth and N tem 27 is n traumatic | Г | - | Francis E. | Whi | te – f | ather | | | | | | ay, | Date | rton, | MD 2 | - City or | Town, State | |
| | permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati | | 2 | 20a. Method of Disposition | | D | l from Ctata | | ce of Dispos | | | | | | | | | | _ |
| - 3 | Daluniore, permit. Pages I a Department of He Important: If ite | | 1 | 1 Burial 2 X Cren | | | I from State B | rins | field- | -Echo | ls C | rema | tory | 2/3 | /08C1 | narlot | te E | la11, M | ע ע |
| | it. P. urtme | | | 4 Donation 5 Oth 21. Signature of Juneral Se | | | | | | | | | | | | | | ral Ho | |
| ć | Dalullore permit. Pages 1 s Department of He Important: If it | 1 | T. | M. + 1 | \ \ : | 1. X TI | MO | 0817 | 130 | 195 T | hree | Note | ch K | d., | cnar. | rotte | натл | , MU Z | 0022 |
| | Physiciar | ۲ | 12 | 23a. Part I. Enver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and | | | | | | | | | | | inset and | | | | |
| | ledica | | | failure. List only one cause on each line. Death Compact Wound of Head | | | | | | | | | | | | | | | |
| | _amine | r | | Immediate Cause (Final disease a. Gurisifor Would of Flead or condition resulting in death) Due to (or as a consequence of): | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | ├ | | | | | |
| | | | ᆔ | Sequentially list conditions if any, leading to immediat | | Due to (or a | s a consequ | ence of): | | | | | | | | | | | |
| | _ | ١ | 티 | cause Enter Underlying ((Disease or injury that initial | ted ' | Due to (or a | as a consequ | ence of): | | | | | | | | | | | |
| V | ed ed | ١, | Š. | events resulting in death) | _ast , | 1 | | , | | | | | | | | | | | |
| | '6U, cate be executed physician and he burial - transit | | ᇹᅡ | UNPENDED | | AMENDE | D. c | 1343 | 276 0/ | 01./00 | mr) | | | | | | | | |
| | e be e ysicia | | Medical | | | ~ 4b & 2 | 28f per | of pregna | 3/6, 2/2 | 21/08 | TT_ | | | | | 23d. Date | of deliver | у | |
| j | 576 ifficati | | | IF FEMALE: 23b. Was decedent pregna | nt in the | | ve birth | o. p g | 2 F | etal death | 3 | Ectopic | c pregna | ncy | | Month | - | Day | Year |
| , | Sox 68/ leath certifing e attending | USC a | E. | past 12 months? | 1 | 7 | egnant at tin | ne of deat | th 5 C | ther (Spe | cify) | | | | | | | | |
| | Box 68 /60 c death certificate b the attending physical for use as the hu | 0.0 | Physician | 1 Yes 2 No 9 | | 9 01 | nknown | | | | | | | 22 | Did toba | CCO USA CO | atribute to | the cause of | death? |
| | at the | | | Part II. Other significant | ondition | s contributir | ng to death b | ut not res | sulting in the | underlying | , cause (| given in Pa | art I. | | | 2 V No | | | Unknown |
| - | P.O. res that t | 20 | Completed by | | | | | | | | - | | | 100 | | 404 | | utopsy finding | s available |
| | ords, P w requires t as been sign | non | eş | | | | | | | | | | | 24 | a. Was an autopsy | 1 | prior to | completion of | cause of |
| | law law has b | JS 7 3 | 림 | | | | | | | | | | | 1 5 | perform Yes 2 | | death? | es 2 | No |
| | tal Recision: The certificate | , pag | 흸 | | | | | | | | 26.Plac | e of Death | (Check | 1.2 | | | 1.7 | | |
| | Division of Vital Records, tal or Attending Physician: The law requints after death. To after death. To after the contribute of the law been is the contribute of the law of t | director, page | 8 | 25. Was case referred to examiner? | iedicai | Hospital: | Inpatient | 2 F | ER/Outpatie | | DOA | Other ₄ | | ng Home | | esidence 6 | Othe | er: Scene | |
| | Physical Control of the Control of t | <u> </u> | .0 | 1 ✓ Yes 2 N 27. Manner of Death | 0 | 28a F | Date of Injury | , - | 28b. Time of | | | ry at Wor | k? | 28d. D | escribe ho | w injury occ | urred | | |
| | Ing Pl | In the | | 1 Natural 5 | Pending | E0{\\ | Ionth, Day, Yea | ır) | FOUND: | | 1 | Yes 2 | No | Subje | ct shot s | self | | | |
| | Vision or Attend after death Director: | y the | <u></u> | 2 Accident | Investig | otion Jan | 31, 2008_ Place of Inju | | 1531 hrs | eet factor | | | | 28f. Lo | cation (Str | eet and Nu | nber or F | Rural Route Nu | ımber, City |
| | ivis or A after Dire | u l | إ≝ا | 3 V Suicide 6 | Could n | ot be | | | | 001, 100101 | y, omoo | Danamy, - | | or 15180 | Town, Sta Deborah | te) Hu Drive, Ga | ignesv litornia , | Rural Route Nu ille, MD | |
| | Division of Vital Records, P.O. Box 68/6U, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physici | completely filled in by the | Certification: | 4 Homicide | _ | 1 1 1 | cify) Sing | | | | n linn - | data and - | lace on | due to | the cause(| s) and man | ner as sta | ated. | |
| | To the Hospital within 24 hours | etely | | 29a. Certifier 1 Certification | ing Phys | ician: To the | e best of my l | knowledge ination an | e, death occ nd/or investig | urred at th jation, in m | e ume, o ny opinio | ate and p n, death o | ccurred | at the tin | ne, date ar | nd place, an | d due to | the cause(s) | |
| | To the within To the | comp | Medical | | | and man | ner stated. | | | | | | | | | 29d. Date s | igned (M | lonth, Day, Yea | ar) |
| | | S 295. Signature and title of certifier | | | | | | | | | | | | | | | | | |
| | | | | Doma Mi | JINO | wti, ~ | ID. | | | | 0.0 | | | | | . 05,001 | ., ., 200 | | |
| | 1. | | - | 30. Name and address of person who completed cause of death (Item 23a) | | | | | | | | | | | | | | | |
| | 7 | | Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 | | | | | | | | | | | | | | | | |
| | | St | ate | 31. Date filed (Month, Da | Year) | 000 | 2 Registrar's | s Signatu | re | and I | | | | | | | | | |
| | Rea | riet | rair | FEB | 3 1 6 | 008 | 1000 | Par | A STATE OF THE PARTY OF THE PAR | - | | | | | | | | | |

Physician /Medical Examiner

Funeral

Director

28a-f show

Item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 Is marked other t any injury or other traumatic event, <u>ti</u>

within 72 hours after

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

or Attending Physician:

the Hospital

certificate be

as the burial-transi and signed by the attending physician I be detached for use as the buria has certificate within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir

Completed Be မ Certification:

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performe 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural (Month, Dav Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

Medical State

Registrar

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

D51426

bruary 4, 2008 Pikesville, mo)

address of person who completed cause of death (Item 23a) (Type, Print)

old Court

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 3, 2008 **Physician** Zinn-Madnick /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Village Montgomery 9704 Inaugural Way If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 90 1 M 2 XF Director 10/21/1917 MA 025-10-9146 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10a. State 10b. County 10c. City. Town or Location Montgomery Village MD Montgomery Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20886 9704 Inaugural Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Saleswoman Department Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Abraham Rosenberg Minnie Budnick ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Valarie Lazerowich - Daughter 17802 Cricket Hill Drive Germantown MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place)
B'nai Brith Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/5/08 Worcester, MA 22. Name and Address of Facility
Danzanksy-Goldberg Memorial Chapels Inc
II/O Rockville Pike Rockville MD 20852 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Cerebrovascular Event disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical

Physician /Medical Examiner

signed by the a

has

To the Hospital or Attending Physician:

page

neral Director; A

within 24 hours a

To the Funeral I

completely filled

<u></u>

Completed

Be

ဥ

Certification:

Medical

Division or Vital Records, P.O. Box 68760,

23b. Was decedent pregnant

9 Unknown

in the past 12 months? 1 ☐ Yes 2 🗷 No

25. Was case referred to medical examiner?

5 Pending

investigation

6 ☐ Could not be determined

1 ☐ Yes 2 ☐ No

27. Manner of Death

1 ₩ Natural 2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death

4☐Pregnant at time of death 9□Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Day

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

24a. Was an autopsy 1□ Yes 2 No 26. Place of Death (Check only one)

1 ☐ Yes 2 【XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼ No

7:10 P_M

10d Inside City Limits 1 ☐ Yes 2 X No

Approximate Interval Between Onset and Death

Year

Days

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifler

0 7 2008

FEB

29c. License number D58874

29d. Date signed (Month, Day, Year) February 4, 2008

30. Name and address arriverson who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Bradley J. Hunter DO 10400 Connecticut Avenue Suite 606 Kensington MD 20895 31. Date filed (Month, Day, Year)

State Registrar

Registrar's Signature 32

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** dAMS 4:10 P.M UGENIA CBruary 21 /Medical 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 4,1ton Avenue Altimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF 212-40-Director 3768 OU 7 1241 MATY/AND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show dical Examiner must be notified at BAltimore 1 XYes 2 No Director MARYLAND 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 224 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) stered Johns Hopkins Nurse + 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be OXNSKI exander 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) South Drughter MEA injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Cen. 4 ☐ Donation 5 ☐ Other (Specify) - 08 21. Signature of Suneral Service Licenses 22. Name and Address of Fa Joseph 263 5. or copplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only the cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease shock, or heart failule. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner COWR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) Yes ed by the 9□Unknown 9 I Inknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy perform certificate 1□ Yes To the Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No ဥ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours after
To the Funeral Dir 29a. Certifier 1🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

PC,

BATTO MUS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301

32 Registrar's Signature

ST

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, **Physician** DD-30A ARMACOST 02 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death Examiner CARROLL HOSPITAL CARRULL WEST MINS TER CENTER VIE 3 | Vinder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. E | September 13,1916 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F 91 220-14-1047 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f show notified at 1 ☐ Yes 2 X No Maryland Carroll Westminster Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be r 21157 97 West Sunshine Way United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: ₩₩ ፲፲ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed by 3 Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) business owner magazine 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maude Dennis Jessie Keemp Armacost ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bonnie M. Cook/daughter 591 Sunshine Way Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Green Mount Crematory Feb. 22,2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland John O. Mitchell IV, Funeral Services of Dulaney Valley, P.A. 200 E. Padonia Rd. Timonium, MD 21093 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one capse on each line. Immediate Cause (Final INELL MONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical the 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Mountain Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy pertormed 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospitat: 1 🔀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA ို 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 □ No after death. 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending within 24 hours a To the Funeral C

Registrar

Medical

Kanu

29b. Signature and title of certifier

(Check only

and manner stated.

29c. License number

D0058580

BOWIE, MD

29d. Date signed (Month, Day, Year)

| 01103 _I I Alexander | 1- | For State | Stat | e of M | laryland / | / Depart | ment of ficate of | Healtr | n and | Menta | l Hygie | re Legit ene Reg. I | | 2 | 008 | 051 |
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| Dhysician | R | egistrar Decedent's Name | (First, Middle, | ast) | | | | | | | | ate of Death | | rear | 3. Time of I | |
| Physician dical Examine | 4 | Paul Al | | | | | | | | | Fe | ebruary 7, | 2008 | | 1633 h | rs |
| | 4 | a. Facility Name (if 1508 Harford | | | | | | b. City, To Baltim | | | | | 4c. Coun | | | 1 |
| Funeral Director | 5 | . Social Security Nu | | Sex | | e (In yrs. last | t birthday) Yrs | If Under Months | | If Under Hours | Min | Date of Birth(| | For | Birthplace (Stat eign Country) | ^{e or} unk |
| v any | _ | | | | | | own or Locat | | | | | | | | 1 | City Limits |
| and f show | <u> </u> | MD | | | | Ва | TUTINOI | 10f. Zip | Code | | | 10g | . Citizen of | What C | ountry? | |
| the Maryl n or 28a-i | Director | 1508 Ha | nber rford I | Road | #305 | | | | 212 | | | | | USA | | Diagk |
| items 23s | Funeral | 11. Marital Status 1 Never Marrie | ur ed 2 Mar | ried | Was Deceden Armed Forces Yes 2 | t Ever in U.S ? UNK ! No | . 13. Wa | as Deceder es, specify | nt of Hisp y Cuban, | anic Origi Mexican, | n? (Specif Puerto Rica | y Yes or No- an, etc.) | \ \ \ | Vhite, etc | | Black, |
| fter de | | 3 Widowed | 4 Divo | rced or Da | s, Give Year | | 1_ | Yes 2 | X No | specify: | | | Spec | | 1ack | 1 |
| 2 hours at "natural | eted by | 15. Decedent's Ed Elementary/Seco | | | phest grade co College (1-4 or | | 16a. Decede during n | nt's Usual (nost of wor | Occupation king life. I | on (Give k DO NOT | ind of work use retired) | done unk | 16b. Kind d | T Busine | ss/maustry | unl |
| 215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica | d la | nk 17. Father's Name (| (First, Middle, | unk ast) | | | | u | nk 1 | 8.Mother | s Name (Fi | rst, Middle, Ma | aiden Surn | ame) | | unl |
| al Hygen | | Tr. Tanio d Tamo | (, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | , | | | | | | | | | | | | |
| 212 212 Ment Ment mark | 의 | 9a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z | | | | | | | | |) | | | | | |
| MD d 2 sho lth and n 27 is | - | O.C.M.E. 111 Penn Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or To | | | | | | | | | e. | | | | | |
| ges I and it of Healt it: If item other tran | | | Cremation | | Removal from S | State C | lace of Dispo rematory or o | sition (Nar other place) | ne of cerr | netery, | D | ale | 200. 2000 | | , 0 | |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. | ŀ | 21. Signature of Fu | 4 Donation 5 X Other Specify: in State 21. Signature of Funeral Service Licensee Renald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Approximate Interval Between Onset and Between Onset an | | | | | | | | | | | | | |
| _Physician | _ | 23a. Part I. Enter the failure. List on | ne disease, or nly one cause | on each III | ne. | | Do not enter | the mode | of dying, | such as c | ardiac or re | espiratory arre | st, shock, | or heart | Betwee | mate Interv en Onset ar Death |
| 'Medical aminer | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause Enter Indertying Cause Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | | | | | |
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| sd sit | Examine | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): | | | | | | | | | | | | | | |
| e execute cian and rial - trar | dical l | UNPENDE |) | dAI | MENDED | | | | | | | | 1 | ate of de | lives | |
| Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Physician: The law requires that the death certificate be executed in Funeral Director: After this certificate has been signed by the attending physician and easily filled in by the funeral director, page 2 should be detached for use as the burial – transit | sician/Medical | IF FEMALE: 23b. Was deceden past 12 month | is? | ne 1 | | at time of de | 2 | Fetal death Other (Sp | | Ectop | ic pregnanc | су | | onth | Day | Year |
| O. Bo at the deat 1 by the at tached for | Phy | 1 Yes 2 Part II. Other sign | | | Unknown | | esulting in th | e underlyir | ng cause | given in F | Part I. | | | | ute to the cause | |
| ds, P.O. equires that th een signed by ould be detach | Completed by | | | | | | | . | | | | 24a. Was | an | 24b. We | ere autopsy fin or to completio | dings avail |
| COr law r has b | npl | | | | | | | | | | | perfo 1 ✔ Yes | rmed? | | ath? ✔ Yes | 2 No |
| Re The ficate | | 05 W/ refe | ered to modic | 1 1 | | | | | 26.Plac | e of Deat | h (Check or | nly one) | | | | |
| ician: | Be | 25. Was case refe examiner? | - | | pital: 1 Inp | atient 2 | ER/Outpati | ent 3 | DOA | Other ₄ | Nursing | Home 5 | Residenc | e 6 🗸 | Other: Scene | |
| n of V ing Phys After this | on: To | 1 Yes 27. Manner of De 1 Natural | | | 28a. Date of (Month, D | Injury | 28b. Time | | | ury at Wo | _ | 28d. Describe | how injury | occurre | d | |
| Division of Vital Records, and or Attending Physician: The law require rs after death. After this certificate has been silled in by the funeral director, page 2 should be in by the funeral director, page 2 should be a second or the funeral director, page 2 should be a second or the funeral director, page 2 should be a second or the funeral director, page 2 should be a second or the funeral director, page 2 should be a second or the funeral director. | Certification: | 2 Accident 3 Suicide | 6 Co | iding estigation ald not be | | of Injury - At I | nome, farm, s | treet, facto | | | | 28f. Location (or Town, | (Street and State) | Number | r or Rural Rout | e Number, |
| Div E Hospital of 24 hours al E Funeral L etely filled | sal Cert | 4 Homicide | | ermined Physician | (Specify) : To the best of | of my knowle | dge, death o | ocurred at t | the time, | date and | place, and | due to the cau | se(s) and | manner | as stated. le to the cause | (s) |

30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Assistant Medical Examiner 31. Date filed (Month, Day Year) FEB 2 2 2008

29b. Signature and title of certifier

OCME

and manner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 8, 2008

State Registrar

| | | 1_ State | | partment of H ertificate of L | | | 0000 | 051.02 |
|---|------------------|--|------------------------------------|---|---|--|---|---------------------------------|
| | | Registrar 1. Decedent's Name (First, Middle, Last) | | crimoate or i | Jean | 2. Date of Death | | 3. Time of Death |
| Physic /Med | | Howard James Burt | on Sr. | | | February | · · · · · · · · · · · · · · · · · · · | |
| Exam | iner | 4a. Facility Name (If not institution, give street and number) 10437 Brighton Road | | 4b. City, Town, or Ocean | Location of Death | | 4c. County of Dea | |
| Funera | 1 | 5. Social Security Number 6. Sex 7. Age | (In yrs. last birthda | | If Under 24 Hrs. Hours Min. | 8. Date of Birth (Month, Day, 7/26/192 | | thplace (State or Foreign |
| Directo | r | 216–16–9429 1 ★ 2 F Usual Residence of Decedent | 83 Yrs. | | | 7/26/192 | 24 | MD |
| yland how at | | 10a. State 10b. County | 10c. City, Town or | | | | | 10d. Inside City Limits |
| he Mar 18a-f sl otified | ector | Worcester | | Ocean City | | 10 | g. Citizen of What C | 1 XYes 2 No |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at | Funeral Director | 10e. Street and Number 10437 Brighton Road | | 10f. Zip Code | 21842 | | USA | |
| r death | Inera | 11. Marital Status 12. Was Decedent Ev Armed Forces? | ver in U.S. | 3. Was Decedent of H If Yes, specify Cuba | ispanic Origin? (Spe an, Mexican, Puerto | ecify Yes or No- Rican, etc.) | 14. Race - Am Black, Whi | |
| rs afte | by Fu | 1 □ Never Married 2 □ Married 1 □ X Yes 2 □ No. If Yes, Give Year or Dates: C | arine | 1 □ Yes X No | Specify: | | Specify: Wh | ite |
| 72 hou natura | | 15. Decedent's Education (Specify only highest grade completed) | 16a. Dec | cedent's Usual Occup | ation during most of worki | ing I | 16b. Kind of Business | /Industry |
| within ane. | Completed | Elementary/Secondary (0-12) College (1-4or 5+ |) \life | ive kind of work done of DO NOT use retired Engineer | i) | | Beverage | Company |
| e filed Il Hygid other | Be Co | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Name | | | |
| ylai ould be Menta arked | 10 E | | 1 | | | | ndutch | |
| IVICAL Id 2 sh Ith and Ith and Ith and Ith and Ith and Ith and | | 19a. Informant's Name/Relationship (Type. Print) Kathleen A. Burton / Daught | | ailing Address <i>(Street</i> 0437 B ri gh | | | | |
| S to H D | | 20a. Method of Disposition | 20b. Place of Dis | sposition (Name of crematory or other place | | Date 2 | 20c. Location - City o | r Town, State |
| Pages 1: Iment of He tant: If Iten | | 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) | Crownsv | ille Veter etery 22. Name and Addre | ans 2/22 | 2/2008 | Crownsvi | .11e, MD |
| permit. Page Department of Important: If any Injury or | 5 | 21 Signature of Funeral Service Licensee Victor | P. Doda | | | Funera | l Home Inc Itimore, N | ர் 21230 |
| | | 23a. Part1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line | the death. Do not (| | | | | Approximate Interval Between |
| Physician | _ | Immediate Cause (Final disease or condition | Store R | ned Draw | | | | Onset and Death |
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| ecute and I-transi | Examiner | Cause (Disease or injury that initiated events c | consequence of): | · | | | | |
| cate be executed physician and the burial-transit | dical E | L _d . | | | | | | |
| rtification ng phy | Medic | IF FEMALE: | | | | | | |
| The COLUS, F.O. BOX 00/00, The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit | Physician/Me | 23b. Was decedent pregnant in the past 12 months? | 2 ☐ Fetal death | 3 ☐ Ectopic pregnancy | у | | 23d. Date of de Month | elivery Day Year |
| the de ached | nvsic | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown | inie oi deatii | | | | | |
| es that gned b | | | t not resulting in the | e underlying cause giv | en in Part I. | | | to the cause of death? |
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| he law he has t | amo | Crany Jamy Branch | | | | 24a. Was a autops perforr | y prior to ned? death? | |
| cian: T certificat ector, pa | Be Co | | | | 26. Place of Deat | | 2 X No | |
| Physic Physic this ce al direc | P | 1 ☐ Yes 2 No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No ☐ No | | tient 3 DOA Oth | 4 Li Nursing Ho | | ence 6XIOther (Sp ow injury occurred | ecity) daughter' s |
| oding I th. : After | tion: | 1 □ Natural 5 □ Pending (Month, Day) 2 □ Accident investigation | | ry Woi | rk? Yes 2 □ No | 20d. Describe no | W Injury occurred | |
| lor Attending Phy after death. Director: After this in by the funeral d | Certification: | 3 Suicide 6 Could not be determined 28e. Place of injuing, etc. | ry - At home, farm, . (Specify) | street, factory, office | | 28f. Location (St City or Town | reet and Number or I | Rural Route Number, |
| pital o | | | f mv knowledge, d | eath occurred at the ti | me, date and place. | and due to the c | ause(s) and manner | as stated. |
| To the Hospital or Attending Physician: The law requires that the death certifuction within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as | Medical | (Check only 2 Medical Examiner: On the basis of one) | examination and/o | | | | | |
| To th To th | M | 29b. Signature and title of certifier | | 29c. Licens | se number | 2 | 9d. Date signed (Mo | |
| | | 30. Name and express of person who completed cause of de | eath (Item 22a) /Tur | | 11009 | | | - 00 |
| | | Joseph Chromon W | 10 | | # Paz | SAU | saray M | 21804 |
| | State | and the second s | r's Signature | A | | | V | |
| Regi | strař | FEB 2 2 2008 | 15 190 | | | | | |

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, To the Hospital or Attending Physician:

27. Manner of Death
1 2 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1🐔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ItUSICIAN V(i) 1)00555 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A-SHALABY out phil 6565 WONTH CHMUS ST

Medical

State

Registrar

Registrar's Signature

CARS

| Division or Vital Records, P.O. Box 68760, | | Baltimore, Maryland 21215-0036 |
|--|--------------------|--|
| n: The law requires that the death certificate be executed | Phys /Me Exa | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. |
| To the Funeral Director: After this certificate has been signed by the attending physician and some sompletely filled in by the funeral director, page 2 should be detached for use as the bunal-transit | | Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at |
| | | |

Funeral Director

| | , | 1- State of No. St | | Certificate of | | , , | eg. No. 20 | 08 | 054 | 04 | | | | | |
|--|---------------|--|---|--|-------------------------------------|----------------------------------|----------------|-------------------------------------|-----------------|-----------------------------|--|--|--|--|--|
| Physicia | an | 1. Decedent's Name (First, Middle, Last) Delia M. Barrett | | | | 2. Date of Deat 02/20/2 | | Year | 3. Time of D | Death A _M | | | | | |
| /Medic | | 4a. Facility Name (If not institution, give street and number | r) | 4h City Town o | r Location of Death | 02/20/2 | 4c. County | of Death | 12:35 | - 101 | | | | | |
| Examin | er | St. Elizabeth Nursing Home | | Balti | | | | /A | | | | | | | |
| Funeral | | Social Security Number 6. Sex 7. A | ge (In yrs. last birth | day) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, | | 9. Birthp | lace (State or | Foreign | | | | | |
| Director | | 219-16-4742 1□ M 2 F 8 Usual Residence of Decedent | 37 Yr | s. Months Days | Hours Min. | 06/07/1 | 920 | Ire | Land | | | | | | |
| how | | 10a. State 10b. County Baltimore | 10c. City, Town o | or Location | | | | 1 | 0d. Inside City | | | | | | |
| a-f s | Director | MD Harford | <u> </u> | Kingsvill | e | | | | 1 🗌 Yes 🤰 | ₹ □ No | | | | | |
| or 28 | Dire | 10e. Street and Number | | 10f. Zip Code | | 1 | 0g. Citizen of | What Cour | itry? | | | | | | |
| s 23a nust I | | 10 Kings Glen Court | | | 1087 | | Unite | | | | | | | | |
| Department of Health and Mentier Hygiene. Institute 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Deceder Armed Forces 1 □ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | ≹No | 13. Was Decedent of H If Yes, specify Cub1 ☐ Yes 2 ☒ No | | ecity Yes or No- Rican, etc.) | Blad | ce - Americ ck, White, y: Whi | etc. | | | | | | |
| e. an "natur Medical I | Completed | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4o | (6) | Decedent's Usual Occup Give kind of work done ife. DO NOT use retire | pation during most of work d) | ing | 16b. Kind of B | usiness/Ind | dustry | | | | | | |
| /gien er tha i, the | Be | 8 | | eteria Wor | ker/Serve | er | Hospit | al Fo | od Serv | <i>v</i> ice | | | | | |
| tal Hy d oth event | | 17. Father's Name (First, Middle, Last) | | | 18. Mother's Nam | | Maiden Surnar | ne) | | | | | | | |
| narke naric | P | Patrick Devaney | T | | | e Nolan | | | | | | | | | |
| h and 7 is n traun | | 19a. Informant's Name/Relationship (Type. Print) Margaret B. O'Connell (Day | | Mailing Address (Street | | | | | | 7 | | | | | |
| Healt em 2 other | | 20a. Method of Disposition | 20b. Place of D | Disposition (Name of | 1 | | 20c. Location | | | | | | | | |
| tment of tant: If it ijury or o | | 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify) | cemetery, | crematory or other pla hedral Cem | etery 02/ | 23/2008 | Balti | more, | Maryla | and | | | | | |
| Depar Impor any ir once, | | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21. 23a. Partl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate the processing of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate the processing of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, | | | | | | | | | | | | | |
| - 58 | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death | | | | | | | | | | | | | |
| ysician | | disease or condition resulting in death) a. METASTATIC BREAST CANCER TO 4 MONTH | | | | | | | | | | | | | |
| Medical aminer | | Bue to (or as a consequence of): BONE AND LIVER | | | | | | | | | | | | | |
| 3 | Em (I) | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or influry that initiated events resulting in death) Last b. KICHT BREAST CANCER Due to (or as a consequence of): LEFT BREAST CANCER 36 489 Due to (or as a consequence of): | | | | | | | | | | | | | |
| nsit. | nin | | | | | | | | | | | | | | |
| ng physician and e as the burial-transit | Examiner | | | | | | | | | | | | | | |
| ysicia ne bur | edical | | | | | | | | | | | | | | |
| ng ph | 5 | IF FEMALE: | | | | | | | | | | | | | |
| ed for use | ysician// | 23b. Was decedent pregnant in the past 12 months? | e pf pregnancy 2 ☐ Fetal death at time of death | 3 ☐Ectopic pregnanc 5 ☐ Other (specify) _ | у | 3 | | ate of delive onth | | ear | | | | | |
| ned b e deta | by Phy | Part II. Other significant conditions contributing to death | | | | | | | ne cause of de | ath? | | | | | |
| en sig d blud | | ESSENTIAL HY | PERTE | NSION | | 1 □ Ye | es 2 No | 3 ☐ Prob | ably 4 🔲 Ur | iknown | | | | | |
| e has ber age 2 sho | Completed | | | | | 24a. Was a autops perform | ned? | prior to co death? | psy findings av | /ail <i>a</i> ble use of | | | | | |
| rtificar tor, p | a) | 25. Was case referred to medical | | | 26. Place of Deat | | | 1 □ Yes | 2 100 | | | | | | |
| direc | To B | examiner? 1 ☐ Yes 2 X No Hospital: 1 ☐ Inpa | tient 2 ER/Outp | atient 3 DOA Oth | ner: 4 Nursing Ho | ome 5 Reside | ence 6 Oth | ner <i>(Sp</i> ecit | y) | | | | | | |
| rr. After the funeral | | 27. Manner of Death 1 | jury 28b. Tin Day Year) Inju | ury Woi | | 28d. Describe ho | w injury occur | red | | | | | | | |
| I Directo | ertification: | 3 Suicide 6 Could not be determined 28e. Place of i building, 1 | njury - At home, farm etc. <i>(Specify)</i> | n, street, factory, office | | | | | | er, | | | | | |
| e Funera e Funera letely fille | edical C | 29a. Certifier (Check only one) 1 Certifying Physician: To the besis and manner: and manner on the besis and manner. | and due to the c rred at the time, d | ause(s) and m ate and place, | anner as s and due to | tated. the cause(s) | | | | | | | | | |
| To th comp | Me | 29b. Signature and title of certifier | | 29c. Licens | se number | 2 | 9d. Date signe | ed (Month, | Day, Year) | | | | | | |
| | | Nomal lesay me |) | DO | 01836 | 2 | 2 | -21- | 2008 | | | | | | |
| 6 | | 30. Name and address of person who completed cause of KOMAL K DAYA MD: | death (Item 23a) (T) | ype, Print) Kens Ave | . Suite | 40, € | 3a Hir | nove | Mela | 21229 | | | | | |
| Sta | te | 31. Date filed (Month Day Year) 22. Regis | trar's Signature | Could to | | , | -0 1111 | | 1 | | | | | | |
| Registr | ar | LDN & COOO | 1 150 19 | | | | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 05405 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 19 Physician Boone Julia Ann 2008 1:40 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 8. Date of Birth April 23, 1923 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 213-20-4244 1 M 2 XF Mary land 84 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural"; or Items 23a or 28a-f show any lijury or other traumatic event, the Medical Examiner must harmast harmatic event, the Medical Examiner must harmatic event, the Medical Examiner must harmatic event, and the market events harmatic events. 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 ☐ Yes 2√☐ No Director Baltimore Towson Md. 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 43 Theo Lane 21204 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Insurance Co. Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosina Krupple John Hart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. E. Dwight Lipin/ Nephew 7511 Oldchester Rd. Bethesda, Md. 20817-6162 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. 2-23-08 Timonium, Md. 4 Donation 5 Dother (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral price License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator, arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Subdural Hematoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Accidental Fall Sequentially list conditions if any, leading to inmedite cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-trar Due to (or as a conseque Box 68760 pe Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No Day Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 ☐ Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an he lay autopsy perform this certificale 2**X** No or Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 X Yes 2 □ No 2 ER/Outpatient 3 DOA 1 Xnpatient Certification: To 27. Manner of Death 28a. Date of Injury 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Division (Month, Day Year) 1 □ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death. 2-17-08 1300M Fall from standing 2 X Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 5501 Southwick Street 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Home determined 4 Homicide Bethesda, Md. 20817 within 24 hours at To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature art title of certifier D42181 February 20, 2008 D 30. Name and address of person who completed cause of death tem 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Daza Enrique, MD

31. Date filed (Month, Day, Year)

1340

19/08

Boone

Bethesda, Md.

Suburban Hospital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** \mathbf{P}^{M} 18, February 2008 1:20 Marian Bernd /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 X F 77 Virginia April 26, 1930 Director <u>579-36-5031</u> Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at show 1 ☐ Yes 2X No Director Maryland Frederick Monrovia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or Items 23a or the Medical Examiner must be United States 11526 Fingerboard Road 21770 Funeral death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. White Specify: 9 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contracting Officer U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be nt of Health and Mental I: If item 27 is marked o or other traumatic eve Paul William Brooks Ella H. Griggs 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11526 Fingerboard Road, Monrovia, MD 21770 |Diane M. Switlick / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition February 22, 1 ☐ Burial 2 X Cremation 3 Removal from State Department of Important: If any Injury or 2008 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium Bethesda, Maryland 22. Name and Address of Facility Robert A. ockville, Inc., 300 West ockville, Maryland 20850-Pumphrey Funeral Home/ Montgomery Avenue, 2805 21. Signature of Funeral Service Licensee Rockville, Rockville, M01473 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Weeks Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Heart Failure Weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician s the buria Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has birector, page 2 s autopsy performed 2X No Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 412 Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. | Director: / 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

10

31. Date filed (Month, Day, Year) FEB 2 2 2008 Registrar

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

the

29c. License number

D20148

29d. Date signed (Month, Day, Year)

February 19, 2008

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 05408 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 7:15 PM Annarose Sleeth Bowers 20 2008 February /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Oak Crest Village - Care Center Baltimore Parkville 9. Birthplace (State or Foreign Country)
Dist. of Columbia 6. Sex if Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year May 16, 19 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 X F 86 577-22-1243 1921 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the M-di-al Examiner must be notified at Baltimore Parkville 1 ☐ Yes 2 No Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 8810 Walther Blvd., Apt. 2106 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: white Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) legal attorney 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Florence Evelyn Althouse James Riker Sleeth ဥ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Baltimore, MD Clarke D. Bowers/son 21218 Department of Health Important: If item 27 any Injury or other troone. Chancery Sq. altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Loudon Park Cemetery Mar. 1, 2008 Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home,
6500 York Rd. Baltimore, MD 2 21. Signature of Funeral Service Licensee John O. Mitchel Approximate Interval Between Onset and Death Ant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequen): Examiner rheumatoid arthrit Sequentially list conditions, it any, leading to infine distances. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Over to for as a cur secuence of Physician/Medical Examiner the burial-transi Due to (or as a consequence of) P.O. Box 68760 physician as IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 Unknown a astroesophosea rheumatica. 1 Tyes 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate 1□ Yes 2110 Division or Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation n 24 hours after death.

The Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely f (Check only and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

FEB 2 2 2008

Her Bud, Parhville, MDZ1234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | 1 - For State Registrar | State of N | /larylan | • | | | ealth a | and M | • | giene Reg. No. | 008 | 054 | 09 |
|---------------------|--|-------------------|---|---|---------------------|--|--|----------------------------|------------------------|-----------------|--------------------------------|-------------------|-------------------------|--|----------|
| | Physici | an | Decedent's Name (First, Middle, Last | | | | | | | | 2. Date of De Month | Day | Yeer | 3. Time of D | |
| | /Media | cal | John Bishop 4a. Facility Name (If not institution, give | street and numbe | ur) | | 4h Cih | Town or | Location o | | Februar | | 2008 unty of Dea | 3:20 P | IAT IAI |
| 7 | Examir | ier | Manor Care Rossv | | •, | | | ltim | | Doain | | | altim | | |
| | Funeral | | 5. Social Security Number 6. Se | 7. / | Age (In yrs. i | last birthday) | If Unde | r 1 Year | | 24 Hrs. Min. | 8. Date of Bir | | | | Foreign |
| | Director | | 579-05-72/4 | M 2□F | 91 | Yrs. | Ay) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Sept 3, 1916 Mary Land | | | | | | | | |
| | and ** | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City | y, Town or Lo | cation | | | | | | | 10d. Inside City | Limits |
| | Maryl 1 eho | jo | MD Harford | | | Edgewo | | | | | | | | 1 ☐ Yes 2 | ZX No |
| | r 28a | Director | 10e. Street and Number | | 1 | | 10f. Z | p Code | | | | 10g. Citizen | of What C | ountry? | |
| | th with | ai | 877 Cloverleaf Co | ırt | | | | 2 | 21040 | | | US | SA | | |
| | r dea | Funerai | 11. Marital Status | 12. Was Deceder Armed Forces | nt Ever in U. s? | .S. 13. | Was Dec | dent of Hi | ispanic Orig | gin? (Spe | cify Yes or No Rican, etc.) | 14. | Race - Am Black, Whi | encan Indian, ite, etc. | |
| 36 | s afte | by Ft | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ∐Yes 2 ☐ If Yes, Give Year or Dates | - | 1 | | | Specify: | | | | ecify: b | lack | |
| 9 | filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f ehow int, the Medical Examinar must be mailfied at | | 15. Decedent's Edu | | ·. | 16a. Dece | dent's Us | ual Occupa | ation | | | 16b. Kind | of Business | s/Industry | |
| 215 | hin 72 | Completed | (Specify only highest grad | e completed) College (1-40 | r 5+) | (Give | kind of w DO NOT | ork done d use retired, | during most () | of working | ng | | | , | |
| 21 | od wit | Соп | | nk | , | | cha | ıffer | | | | | | tation | |
| Ind | tal Hydral Hydral Hydral | Be | 17. Father's Name (First, Middle, Last) | | | | | | 18. Mothe | r's Name | (First, Middle | Maiden Sui | mame) | | unk |
| Maryland 21215-0036 | should be Ind Mental I | 2 | George Bish 19a. Informant's Name/Relationship (7) | | | 10h Mailie | - Add- | n (Ctroot o | and Alumba | e or Rum | Route Numb | or City or To | State | Zin Code) | |
| <u>s</u> | d 2 st th and t7 to r traur | | Cheryl Walker/n | | | 1 | | | | | dgewood | | 2104 | _ | |
| | s 1 and 1 Health Item 27 other ti | | 20a. Method of Disposition | | 20b. P | lace of Dispo | sition (Na | me of | | | ate | | ion - City o | r Town, State | |
| Ë | Pages nent of h int: If ite | | t ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 🖾 Other (Specify) | | (0 | emetery, crei | natory or | Otrier praci | 9 | | | | | | |
| Baltimore, | permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'eny injury or other traumatic event, than Monea. | | 21. Signature of Foneral Service Licens | Vade, Din | rector | | State | nd Addres Anat more, | ss of Facility LOMY I | Board 2120 | 1 655 W | . Balt | imore | e Street | |
| | | | 23a. Part1. Enter the disease, or comp. shock, or heart failure. List only o | ications that caus | ed the death | | | | | | | rrest, | | Approximate Interval Between | een |
| | Physician | | Immediate Cause (Final disease or condition | Son | 515 | | | | | | | | | Onset and De | eath |
| | /Medical Examiner | | resulting in death) | Due to (dr a | as a conseq | uence of): | | | | | | - | | | |
| | LAdillilei | <u></u> | Sequentially list conditions, | o | as a consequ | | | | | | | | | | |
| | ted nsit | nine | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Dag (0) 8 | 23 & CO1138Q1 | derice or). | | | | | | | | | |
| Ċ. | execu n and iaf-tra | Examiner | that initiated events resulting in death) Last | Due to (or a | as a consequ | uence of): | | | | | | | | | |
| 8760, | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit | | (| d | | | | | | | | | | | |
| 89 | ng ph | Physician/Medical | IF FEMALE: | | | | | | | | | | | | |
| Вох | death certifica attending ph d for use as th | lan/I | 23b. Was decedent pregnant in the past 12 months? | 3c. If yes, outcom 1 ☐ Live birth | 2 Feta | Ideath 3[| | regnancy | | | | 23d | . Date of de Month | • | ear e |
| 0 | he de the a | ysic | 1 Yes 2 No | 4□Pregnant 9□Unknown | | eath 5∟ | Other (| pecify) | | | | | | | |
| P.0 | es that the de igned by the be detached | | Part II. Other significant conditions co | ntributing to death | but not resi | ulting in the u | nderlying | cause give | en in Part I. | | 23e. Did 1 | obacco use | contribute | to the cause of de | ath? |
| of Vital Records, | n sign | d by | Dysphaoia | | | | | | | | 1 🗆 | Yes 2□N | lo 3∏F | Probably 4 Dur | nknown |
| Ö | sw requir s been si 2 should | Completed | L a g | | | | | | | | 24a. Was | an 2 | 4b. Were a | autopsy findings at completion of car | vailable |
| R | The lav ate has page 2 | E | | | - | | | | | | auto perfo | ormed? | death? | es 2 No | use or |
| ita | ysician: The is certificate hi director, page | Bec | 25. Was case referred to medical examiner? | | | | | | 26. Place | of Death | (Check only | | | | |
| Ž | Physician: rthis certifica ral director, i | ို | 1 ☐ Yes 2 No | | | ER/Outpatier | | | 4 Nu | | ne 5□Resi | | | ecify) | |
| | ding P | in o | 27. Manner of Death ↑ Natural 5 ☐ Pending | 28a. Date of Ir (Month, I | Day Year) | 28b. Time o Injury | f M | 28c. Injury Work | yat k? Yes 2 □ t | | 28d. Describe | how injury o | ccurred | | |
| Division | Attending r death. | Certification; | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be | 28e. Place of | Injury - At ho | ome, farm, str | | | 165 2 | | 8f. Location (| Street and N | lumber or F | Rural Route Numb | 10r. |
| Θį | i or A after Dire | ertii | 4 Homicide determined | building, | etc. (Specify | y) | 000, 1400 | , 0,,, | | | City or To | wn, State) | | | |
| | To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral | edical C | 29a. Certifier Certifying Phy (Check only one) | | of examina | | | | | | | | | | |
| | To th within To th compl | Me | 29b. Signature and title of certifier | | | | 2 | c. License | e number | . ^ | | 29d. Date s | igned (Mor | nth, Day, Year) | |
| | | | mule | MD | | | | 02 | 1047 | 14 | | 211 | 5/6 | 8 006 | |
| | | | 30. Name and address of person who co | ompleted cause o | f death (Item | 23a) (Type, | Print) | | 0 0 | 0 | 21 0 | 5 | 10.0 | Bunie | V . N |
| | | | | CLOV Baci | +8 4 | - | alcu | podel | K Ar | of c | Ste 10 | VU | NU | UUMIE | MU |
| | Sta Registr | | 31. Date filed (Month Day, Year) 2008 | 2. negi | Sual S Signa | A STATE OF THE PARTY OF THE PAR | | | | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗍 1 - For Stete Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Brancato 3.50 PM Eloise 2008 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Ellicott City** Howard Ellicott City Health & Rehab Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Jun 7, 1918 9. Birthplace (State or Foreign Country)

W VΔ 6. Sex Funeral 235-22-1930 1 □ M 2 💢 F Months Days Hours Min 89 W. VA Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other then "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other then "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at MD Clarksville Howard 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7370 Hallmark Rd. 21029 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian, 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify þ If Yes, Give 7 Year or Oates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government luch 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lula A. Nichols Josephus Fluharty 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is eny injury or other trau Once. 8618 Open Meadow Way Columbia, MD 21045 Ann Tartanian 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Feb 16, 2008 Fulton, MD 4 ☐ Donation 5 ☐ Other (Specify) St. Paul's Lutheran Cemetery 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Funeral Ser 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Cardiovascelar Dean **Examiner** Thero Scleno lic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed Senile Due to (or as a consequence of): burial-P.O. Box 68760, attending physician for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an 1 ☐ Yes 2 director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No 4 Vursing Home 5 □ Residence 6 □Other (Specify) 2 1 Inpatient 2 EP/Outpatient 3 DOA this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 5 Pending investigation 1 Natural 2 Accident after death Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 T Homicide within 24 hours aft To the Funerel Di completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 30641

Registrai DHMH 17 Rev 1/2001

30

Beck River

Neek Koad

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201-109

32 Registrar's Signature

Sabapathi

31. Date filed (Month, Day, Year)

rebruary

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | State of Maryland / Department of Health and I State of Maryland / Department of Health and I Certificate of Death | Mental Hy | Ga U | 08 05 | 5411 |
|---|------------|---|-------------------------------------|-------------------------------------|--|-----------------------------------|
| | | Decedent's Name (First, Middle, Last) | 2. Date of De | | | ime of Death |
| Physicial /Medica | _ | FORREST MARK BEALL | Month FEBRUA | Day RV 15 | Year 2008 5 | :51 P M |
| Examine | - | 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death | | 4c. County | | |
| | | 2412 A Willoughby Beach Road Edgewood | | Harf | ord | |
| Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 1X M 2 F Yrs. Months Days Hours Min. | (Month, Da | y, Year) | 9. Birthplace (S Country) | state or Foreign |
| | | 217-64-1218 55 Yrs. Usual Residence of Decedent | Aug. 9 | , 1952 | Iowa | |
| rylan rylan | | 10a. State 10b. County 10c. City, Town or Location | | | 10d. Ins | side City Limits |
| So Man 1 | Director | Maryland Harford Edgewood | | | 1 |]Yes 2⊠No |
| Aith the Air of | | 10e. Street and Number 10f. Zip Code | | 10g. Citizen of | What Country? | |
| 75 7 5 8 23 8 23 8 18 18 23 8 18 20 8 18 20 8 18 20 8 18 20 8 18 20 8 18 20 8 18 20 8 | era | 2412 A Willoughby Beach Road 21040 | | USA | | |
| Her deat | Funeral | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puert | pecify Yes or No o Rican, etc.) | - 14. Had Blad | e - American Indi ck, White, etc. | an, |
| 5-0036 AT 551 PM 72 hours after death with the Marylan neturel, or trams 23e or 28e-f show stell Ereptive must be profitted at | þ | 1 ☐ Never Married 2 ☐ Married 1 第 Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: | | Specify | White | |
| AREST 3-75-08 1215-0036 AT 551 PM within 72 hours after death with the Maryland sne. then "neturel", or Itams 23a or 28a-f show to Madical Eraphretinal by notified at | Completed | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work) | ting | 16b. Kind of Bi | usiness/Industry | |
| AREST PARTIES IN The Within 72 hours in the matter in the | du | Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired) | Kii ig | | | |
| S S S S S S S S S S S S S S S S S S S | | 12 Groundskeeper 17. Father's Name (First, Middle, Last) 18. Mother's Nam | no /Firok Adiabatha | | ent Comp | lex |
| E galaby | o Be | Forrest Rex Beall Iris G | | | 16) | |
| | ၉ | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ru | | - | State. Zip Code) | |
| ₹ 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 | | Dennis F. Beall / Brother 2412 Willoughby Beach | | | | |
| | | 20a. Method of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) | Date | 20c. Location - | City or Town, Sta | ate |
| By Pages ment of the ury or or | | 1 ☐ Burial 2√3 € remation 3 ☐ Removal from State 1 ☐ Burial 2√3 € remation 3 ☐ Removal from St | 2-08 | Towson | , Maryla | nd |
| Baltimol Permit. Pages Department of Importent: If it any injury or o | | 21. Signature of Foneral Service Licensee 22. Name and Address of Facility McComas Funeral Ho | me. P.A | _ | | |
| 20380 | 1 | 1317 Cokesbury Roa | d. Abin | adon, Ma | | |
| | | 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final | | | Interva | ximate al Between and Death |
| Physician /Medical | | disease or condition resulting in death) | los d | usease | | |
| Examiner | | Due to (or as a consequence of): | | | | |
| | Je. | Sequentially list conditions, if any, reading to immediate cause. Enter Indexting. | | | | |
| 68760, cate be executed physician and the burial-transit | E a | rany, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause) | | | | |
| 18760, cate be execuply, sicient and the burial-tra | | resulting in death) Last Due to (or as a consequence of): | | | | |
| 68760, ificate be experience of physician as the burial experience of the physician as the | dical | d | | | | |
| Box 6: leath certific attending p | (L) | IF FEMALE: 23c. If yes, outcome of pregnancy | | 024 Dat | n né dniù na | |
| P.O. Box (hat the death certified by the attending letached for use a letached for use a Physician/M. | Clar | 23b. Was decedent pregnant in the past 12 months? 1 | | Z30. Dat | e of delivery nth Day | Year |
| P.O. nat the d d by the letached | nys | 9 Unknown | | | | |
| of Vital Becords, P.O. Box 6 Physicien: The law requires that the death certif r this certificate has been signed by the attending ral director, page 2 should be detached for use as | y y | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did to | bacco use conti | ribute to the cause | e of death? |
| cord v requir been si should I | Led Led | None | 1 🗆 Y | es 2□No | 3 ☐ Probably | 4 Unknown |
| al Record The law requir cate has been si | oble . | | 24a. Was autop | an 24b. V | Vere autopsy find prior to completion | ings available |
| The cate to page | 5 _ | | perfor | med? ! c | leath? □Yes 2 X No | |
| Vital Ficien: The certificate rector, pag | Ω | 25. Was case referred to medical examiner? Hospital: Cther. | th (Check only o | ne) | | |
| Of N Physical Physical directions of the Physical direction of the Phy | | 1 Yes 2 □ No | ome 5 Resid | ence 6 Othe | | |
| VISION Attending Ir death. ector: After by the funer ification: | | 1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident investigation M 1 Yes 2 No | Zod. Doddibo ii | ow injury cocurr | 50 | |
| Division of Vital Records, for Attending Physicien: The law requires the after death. Director: After this certificate has been signed in by the tuneral director, page 2 should be ertification: To Be Completed by | 3 | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office | 28f. Location (S | treet and Numbe | er or Rural Route | Number, |
| Division criter or Attending Parts after death. Tel Director: After ted in by the tuners Certification: | | | City or Tow | | | |
| Division of Vital Re To the Hospital or Attending Physicien: The Within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | Z Z | 29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) | and due to the ored at the time, or | ause(s) and ma date and place, a | nner as stated. and due to the cau | ıse(s) |
| To the complete of the complet | 3 | 29b. Signature and title of certifier 29c. License number | 4 | 29d. Date signed | I (Month, Day, Ye | ar) |
| | | Remark A Guller MD MAF DO014206 | 1 | la . | 18 200P | • |
| _ | ; | 30. Name and address of prison the completed cause of death (Item 23a) (Type, Print) | | vully ! |) | |
| | | BERNARD J. YUKNA MO, DME 1614 CHURCHVITTE RA BEL | NR MO | 21015 | 18,2008 | |
| State Registrar | 1 | 31. Date filed (Month, Day, Year) 32. Registrar's Signature | | | | |

08-01257 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene John Harris Carter 1- For State Certificate of Death Registrar 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) Month Day February 13, 2008 1011 hrs ohn Medical Examine 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** St. Agnes Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. **Funeral** Director 36 Yrs 1 VM 2 Country) Mary ar Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Yes 2 No death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code US Funeral 14. Race - American Indian, Black, Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 Married Yes 2 No specify: If Yes, Give Year Yes 3 Widowed Divorced "natural", 2 16b. Kind of Business/Industr 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than " the Medical Baltimore, MD 21215-0036 unen 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address 20b. Place of Disposition (Name of cemetery, 20a. Method of Dispositi crematory or other place) 2 Burial Donation 5 Other Specify: 22. Name and Address 21. Signature of Fufieral Service License proximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and failure. List only one cause on each line. /Medical Death Cocaine and methadone intoxication Immediate Cause (Final disease ~xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical X UNPENDED ficate has been signed by the attending physician page 2 should be detached for use as the burial #MENDED7, 28a-f, perME, g876, 2/25/08 TI Division of Vital Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth Ectopic pregnancy Fetal death past 12 months' Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy this certificate has t I director, page 2 sh death? performed? Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other 4 Inpatient 2 V ER/Outpatient 3 Nursing Home 5 this 5 1 ✓ Yes No 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28d. Describe how injury occurred After 28b. Time of Injury 27. Manner of Death Certification: 1 Natural Yes 2 y No Pending Fnd 2/13/2008 Fnd 9:00 am unk 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be 3 Suicide

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

To the Hospitar o. . . within 24 hours after death.
To the Funeral Director: Af

State Registrar

Medical

31. Date filed (Month, Day, Year) FR 2

determined

Homicide 29a. Certifier 1

29b. Signature and title of certifie

Carol Allan, MD

30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

(Specify) residence

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

or Town, State) 2610 Cole St.

Baltimore, MD

29d. Date signed (Month, Day, Year)

February 14, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistrarAmend #12,perFD, g876, 2/28/08 TT Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death EBRUARY 20, 2008 **Physician** Alfonso Raymond Cuomo 06:00AM /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Towson Baltimore 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 82 Yrs. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 08-10-1925 Birthplace (State or Foreign Country) **Funeral** Days 220-12-6465 Director Mary land Usual Residence of Decedent death with the Maryland 10c. Cify, Town or Location 10a. State show 10d. Inside City Limits r 28a-f show notified at 1 ☐ Yes 2 X No Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be a 847 Bosley Avenue 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2010 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates:1943–1946 1 ☐ Yes 2 No Specify Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ni any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Budget Analyst Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pascal Cuomo Mary Lena Macklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Cuomo/Wife 847 Bosley Ave., Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other p. Hilltop Service Corporation Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 02-22-2008 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee 1050 York Road, Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC NON SMALL CELL LUNG CANCER /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi Exami that initiated events resulting in death) Last and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 1 ☐ Yes 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No has autopsy performe funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA P After this 27. Manner of Death Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending (Month, Day Year) Injury To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOON FOH LIM. M. D 7601 OSLER DRIVE TOWSON. MARYLAND 21204

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 6:45 AM Michael Peter Calvitto 02-21-2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 109 C. Versailles Cr. Towson Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 09-13-1930 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**⊠**M 2□F 77 039-16-7409 Rhodé Island Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State Baltimore 28a-f show Towson 1 ☐ Yes 2 No Director must be notified 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 109 C. Versailles Circle 21204 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 No Specify: ò 3 Widowed 4 Divorced Year or Dates: 'natural", the Medical Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Salesman Paint permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other this any injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Matteo Calvitto Rosina Cicotti 2 19a Informant's Name/Relationship (Type, Print) Eileen Calvitto/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 C. Versailles Circle, Towson, MD Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Rhode Island VA 1 Burial 2 □ Cremation 3 □ Removal from State 02-25-2008 Exeter, RI 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Ruck Towson Funeral Home, Inc. 21. Signature of Faneral Set 1050 York Road, Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Qnset and Death Immediate Cause (Final **Physician** nuonic years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 3□ DOA 1 🔲 Inpatient 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, death within 24 hours after death

To the Funeral Director:
completely filled in by the

the Maryland

with

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

Certification: To Medical

6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and manner stated.

29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

11+1

North Charles Suite 205 69 32. Registrar's Signature 31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | | artment of Health and Mental Hy <i>rtificate of Death</i> | /glene Reg. No. 2008 05415 |
|-------------------|---|-------------------------------|---|---|--|
| ì | Physici | | 1. Decedent's Name (First, Middle, Last) Robert Lee Carroll | 2. Date of D Month Februa | Day Year |
| | /Medio Examir | | 4a. Facility Name (If not institution, give street and number) 1127 River Road | 4b. City, Town, or Location of Death Sykesville | 4c. County of Death Howard |
| -2 | Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 219–32–5669 TM 2 F 72 Yrs. | · | irth 9. Birthplace (State or Foreign Country) MD |
| | Maryland a-f show ified at | ctor | Usual Residence of Decedent 10a. State | | 10d. Inside City Limits 1 □ Yes 2X1 No |
| | h with the 3a or 28 st be not | al Dire | 10e. Street and Number 1127 River Road | 10f. Zip Code 21784 | 10g. Citizen of What Country? USA |
| 980 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | Completed by Funeral Director | 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 14 Yes 2 No 1961 - Wes, Give Year or Dates: 1962 | Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify: | o- 14. Race - American Indian, Black, White, etc. Specify: white |
| 21215-0036 | í within 72 ho piene. r than "natu the Medical | ompletec | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 milk | dent's Usual Occupation kind of work done during most of working DO NOT use retired) deliveryman | 16b. Kind of Business/Industry dairy |
| Maryland 2 | 12 should be filed within ' h and Mental Hygiene. 7 is marked other than " traumatic event, the Mec | To Be C | 17. Father's Name (First, Middle, Last) Henry Jacob Carroll Sr. | 18. Mother's Name (First, Middle Marie Evely | e, Maiden Surname) rn Poff |
| | and 2 shousalth and Market 127 is mailer traumai | | | ng Address (Street and Number or Rural Route Num River Rd., Sykesville, M | |
| Baltimore, | permit. Pages 1 a Department of He Important: If item any Injury or oth | | I Lybunal 2 Defination 3 Definition State 1. | position (Name of matory or other place) 2-23-08 | 20c. Location - City or Town, State Marriottsville, MD |
| Balti | permit. Departr Imports any Inje | | | 2. Name and Address of FacilityHaight Funds. O. Box 195 Sykesville, | |
| 68760, | Physician pe executed as the private as the private transit as the private transit. | sal Examiner | 23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | ter the mode of dying, such as cardiac or respiratory. Court Small all Lux 2 HAS MASIS | Approximate Interval Between Onset and Death I O MOW I |
| P.O. Box 68 | eath cer attendir for use | Physician/Medical | | □Ectopic pregnancy □ Other (specify) | 23d. Date of delivery Month Day Year |
| | w requires that the do been signed by the should be detached | þ | Part II. Other significant conditions contributing to death but not resulting in the u | | tobacco use contribute to the cause of death?] Yes 2 No 3 Probably 4 Unknown |
| or Vital Records, | | Completed | | 24a. Wat aut per 1 Yes | opsy prior to completion of cause of death? |
| Division or Vita | To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 | Certification: To Be | 25. Was case referred to medical examiner? 1 | of 28c. Injury at Work? M 1 Yes 2 No reet, factory, office 28f. Location | one) sidence 6 □Other (Specify) how injury occurred (Street and Number or Rural Route Number, own, State) |
| _ | Hospital 24 hours a Funeral etely filled | Medical Ce | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal (Check only one) 1 Medical Examiner: On the basis of examination and/or in anner stated. | th occurred at the time, date and place, and due to the total transition, in my opinion, death occurred at the time | e cause(s) and manner as stated. e, date and place, and due to the cause(s) |
| | To the within To the comple | Me | 29b. Signature and title of certifier | 29c. License number | 29d. Date signed (Month, Day, Year) |
| _ | 10 | | 30. Name and address of person who completed cause of death (Item 23a) (Type, | Center St Westn | unster MD 21157 |
| de | Sta Registi | | 31. Date filed (Month, Day, Year) See 2 2 2008 32. Registrar's Signature | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 20, 2008 12:40 A^{M} James Cole February Robert /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 526 Lawson Way Montgomery Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours 1**X** M 2□ F Months Days 1925 Washington, D.C. 82 579-22-7676 March 6, Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show 1 X Yes 2 □ No iral", or items 23a or 28a-f sh Examiner must be notified Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20850 United States 526 Lawson Way Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. be filed within 72 hours after ontal Hygiene.
It other than "natural", or iter 2□No 1943-1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No White Specify. þ Specify: 1966 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Lieutentant Colonel / Pilot Armed Forces 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clark Carlton Beardsley Annie Eva 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 526 Lawson Way, Rockville, Maryland 20850 Phyllis Jean Cole / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 February 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc 23, 2008 Bethesda, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home / Rockville, Inc. Ingelette Barrio M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Let the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 8 Months Non Small Cell Lung Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-trans Due to (or as a consequence of): Box 68760, attending physician certificate be Physician/Medical use as the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy φ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) n signed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Ischemic Cardiopmyopathy, Malignant Pleural Effusions icate has been sig , page 2 should b 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an perform rmed? 2 No certificate 1□ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes _ 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🕅 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0 VA \$1\$1238627 08 30. Name and address of person who completed cause of de iffr (flem 23a) (Type, Print) Casey Flanagan, M.D. 8901 Wisconsin Avenue, Bethesda, Maryland 20889 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 22 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2008 TOSEPH CHO 02 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CROSS HOSPITAL SPRINI If Under 24 Hrs. NER MONTGOMERY 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

MARYLAWD 7. Age (In yrs. last birthday) **Funeral** 110M 2□ F Days Hours Min. Months Director A M Usual Residence of Decedent the Maryland 10b. County r 28a-f show notified at 10a State 10c. City. Town or Location 10d. Inside City Limits 1 Ves 2 No Director SILUER SPRINC MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o eq filed within 72 hours after death with 20902 USA ral", or Items 23a Examiner must b 2405 HERMIF AGE by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 2 No 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ASI KN 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical than College (1-4or 5+) Elementary/S9condary (0-12) TURANT PURANT d other t event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ith and Mental h Be Pages 1 and 2 should be YOUNG CHC 2 JOUNG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a HOLY CROSS HOSPITAI 1200 FOREST GLEN RD SILVER SPRING MD 290 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any Injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5☒Other(Specify) in state 21. Signature of Linear Service Licensee Director State Anatomy Board 655 W. Baltimore, MD 21201

23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line.

Immediate Calle (Final disease or condition resulting in death)

Due to (or as a consequence of): State Anatomy Board 655 W. Baltimore Street **Physician** /Medical Due to (or as a consequence of): Examiner RETERM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy detached for Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 INCOMPETENT ERVI 1 🗀 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 autopsy performed? the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After t 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 Yes 2 No death. 2 Accident within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year) FEB 2 2 2008

SUSAN

29b. Signature and title of contifier

SM1605 FOREST GLEN RD SILVER 1500 W. 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D31663

29d. Date signed (Mopth, Day, Year)

2008

SPRING MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician 4:10 Kudolph 20 2008 February /Medical 4c. County of Death give street and number, 4a. Facility Name (If not institution, 4b. City, Town, or Location of Death **Examiner** Beltimore Iniversity of 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours **™** M 2□ F Yrs 16, 1947 Virginia Director 217-50-0883 60 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 XYes 2 □ No יייישינונו וו וופוח צו is marked other than "natural", or items 23a or 28a-f st any Injury or other traumatic event, the Medical Examiner must be notified once. Director Bel Air Harford Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 124 Williams Street USA 21014 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Construction 12 Surveyor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jessie Hubbard Ash James Emory Catron 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Dani Deegan / Daughter</u> 3439 Santee Road, Baltimore, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from State 2-23-08 Bel Air Memorial Gdn Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McComas Funeral Home, 21. Signature of Funeral Service Licensee P.A. 50 W. Broadway, Bel Air, Maryland 21014 (uss 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Necotizing /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∏ Yes 2FTNo filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident

Division or Vital Records, P.O. Box 68760 or Attending Physician: after death Director:

To the Hospital o within 24 hours a To the Funeral I

State

DHMH 17 Rev 1/2001

Medical

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Villamea

6 ☐ Could not be

determined

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Greene

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and magner stated. 29c. License number

18230

Baltimore

MD

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

February 20, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year **Physician** 12:05 William S. Despard February 19, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 6. Sex Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days 1**☑** M 2□ F Director 217-42-3952 February 2,1942 Rhode Island Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show ns 23a or 28a-f sh must be notifled 1 ☐ Yes 2 No Directo Maryland | Montgomery Germantown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with Items 23a 13533 Deerwater Drive by Funeral 20874 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō Specify: White 1 ☐ Yes 2 ☑ No Specify. 3 ☐ Widowed 4 ☐ Divorced "natural", er than "natura , the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Item 27 is marked other than other traumatic event. the Man Computer Operator Phone Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rollin Morgan d'Espard Mary Lee Owens ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne M. Nichols / Sister 13533 Deerwater Drive, Germantown, Maryland 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot February 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 4 Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. Bethesda, Maryland Signature of Funeral Service Ligensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01193 300 W. Montgomery Avenue, Rockville, Maryland 20850 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician days MELIVION /Medical Due to (or as a consequence of): Examiner Demen Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Examir physician and the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Tes 2 No 9 Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2☑ No 24a. Was an has certificate has rector, page 2 autopsy performe 1 Yes 2√No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation After Natural (Month, Day Year) Injury 1 □ Yes 2 □ No 2 ☐ Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours are To the Funeral Dir 29a. Certifier Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

MENDHIRAT 31. Date filed (Month, Day, Year) FEB 2 2 2008

29b. Signature and title of certifier

Research BLVP Sucto 2401 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Carolyn Dunn 2:00 PM Feb 18, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Columbia Sunrise Assisted Living of Columbia Howard If Under 1 Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign Country) 1 M 2 M F Days Florida Jun 8, 1924 267-28-0820 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes 2 No Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21046 6500 Freetown Rd. U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No White Specify. Specify. 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tomemoker wn Hom 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **Bess Ethel Betts** James Robert McMichael 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12331 Pine Valley Club Dr. Charlotte, NC 28277 Son Mr. Michael Dunn 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition #∰Burial 2 ☐ Cremation 3 ☐ Removal from State Qincy, FL Feb 23, 2008 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Cemetery Signature of Funeral Pervice Licensee 22. Name and Address of Facility

Physician /Medical Examiner

signed by the a d be detached for

peen

page 2 s certificate has

director,

filled in by the

completely

this funeral (

After

To the Hospital or Attend within 24 hours after death To the Funeral Director:

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

items 23a or 28a-f show ner must be notified at

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23sury or other traumatic event, the Medical Examiner must

permit. Pages 1
Department of H
Important: If Ite
any injury or ot

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division or Vital Records,

Attending Physician:

Director

Funeral

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Completed

Be

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the Maryland

with

disease or condition resulting in death) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-tran and attending physician I for use as the buria

IF FEMALE

23b. Was decedent pregnant

Physician/Medical

þ

Completed

Be

၉

Certification:

23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final

| mplication y one cl | ons that caused the death. Do use on each line. |
|------------------------|---|
| a. E | Due to (or as a consequence |
| b. — | Due to for as a consequence |
| c | Due to (or as a consequence |

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4☐Pregnant at time of death

of): of of):

23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify)

Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043

not enter the mode of dying, such as cardiac or respiratory arrest,

in the past 12 months?

1 Yes 2 No
9 Unknown 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I

| 23e | | | tribute to the cau | |
|-----|---------|------|--------------------|-----------|
| | 1 🗆 Yes | 2 No | 3 ☐ Probably | 4 □Unknov |

24a. Was an autopsy perform

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Day

Year

Approximate Interval Between Onset and Death

| | | | | | | 26. | Place of Deat | th <i>(Cl</i> | neck only one) | | ^ |
|------|---------|---|-------------------------------|---------|---------|-------------------------------|----------------|---------------|---|-----------------------|---------------|
| | Hospita | l: 1 Inpatient 2 | 2 ER/Outpatient | 3 🗆 1 | DOA | Other: 4 | 4 ☐ Nursing He | ome | 5 Residence | 6) Other (Specify) | 13313tcc |
| tion | | Date of Injury (Month, Day Year | 28b. Time of Injury | M | 28c. | Injury at Work? 1 ☐ Yes | 2 □ No | 28d. | Describe how inju | ury occurred | |
| t be | | . Place of injury - A building, etc. (Sp | t home, farm, stree ecify) | t, fact | ory, of | fice | | 28f. | Location (Street a City or Town, Sta | and Number or Rural i | Route Number, |

| | | ~ |
|------|----------------------------------|-------------|
| 29a. | Certifier (Check only one) | 2 Medical 8 |

25. Was case referred to medical examiner?

2No

5 ☐ Pending investiga

1 ☐ Yes

27. Manner of Death

1. Natural

2 ☐ Accident

3 ☐ Suicide 4 Homicide 6 Could no determin

g Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Medical | 29a. Certifier (Check only one) | 2 ☐ Medical |
|---------|---------------------------------------|--------------------|
| Me | 29b. Signature and | title of certifier |
| | • | |

M.D.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

| ١ | <u>'</u> } | |
|---|------------|--|
| | | |

State Registrar

31. Date filed (Wonth, Day, Year)
FEB 2 2 2003

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend #5,perFH,g877 3/7/08 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month John Wilson Day February 19, 2008 11:32 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2220 Old Emmorton Road Harford Bel Air If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 219-22-6398 217-12-7136 1**∑** M 2 ☐ F Months Days Director 79 13, 1928 Apr. Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2220 Old Emmorton Road 21015 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ray (nmn) Day Audrey Una Keller ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any Injury or other traum once. Michael K. Day / Nephew 311 Annette Ave., Stevensville, MD 21666 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State IX Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gdn 2-23-08 4 ☐ Donation 5 ☐ Other (Specify) Bel Air, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complete of shall caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hyportensue grationo solerate cardio resculor disease **Physician** /Medical Due to (or as a consequence of): Examiner S quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and physician and s the burial-transit Due to (or as a consequence of): Pivision or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 2 No 24a. Was an certificate ha autopsy performed? 1□ Yes 2 No : After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) ၉ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 X Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Letway 20,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar YUKMA

31. Date filed (Months Day, Year)

MID DME

32. Registrar's Signature

DAY, JOHN

1614 CHURCHVILLE RU BEL AIR Md 21015

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10:50 A^M FEBRUARY 20, 2008 DOROTHY MAE **EDWARDS** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 ☐ M 2 🔀 F 1, 1941 North Carolina Director 213-38-8075 Usual Residence of Decedent 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City. Town or Location 10b. County 10a. State 1 ☐ Yes 2 No 28a-f sh notified Director Maryland Harford Edgewood 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ar than "natural", or items 23a or the Medical Examiner must be r USA 21040 546 Burlington Court Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: p White 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hotel 12 Housekeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Este Nellie Dancy Elmer Ray Spurlin ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1008 Cross Lane, Abingdon, Maryland 21009 William M. Edwards Jr. / Son Baltirhore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages
Department of
Important: If it
any Injury or c IX Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air, Maryland Bel Air Memorial Grdn 2-25-08 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Chronic Obstructive Polmonary Disease Immediate Cause (Final 10 years Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Records, P.O. Box 687 IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 XNo Coccess Cost 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: To 1 ☐ Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Hospital or Attendi 24 hours after death. Funeral Director: A 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 02/21/2008 D35012

State Registrar mosoo upper there yeake Dr. Bel Air, Md. 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 19, 2008 5:20 P M Sara Elizabeth Frederick /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Dec. 31,1942 Funeral 6. Sex Birthplace (State or Foreign Country) Days Months 1 M 2 T F Maryland Yrs. Dec. Director 218-40-3963 65 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ns 23a or 28a-f show must be notified at 1 ☐ Yes 2 X No Director Baltimore Lutherville Maryland 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 'natural", or items 23a Funeral 8404 Saunders Road U.S.A. 21093 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Specify White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Medical If item 27 Is marked other or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carroll Ausherman Margaret Sanbower ပ္ Μ. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8404 Saunders Road Lutherville, Maryland 21093 Paul Frederick, Sr. Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge
Memorial Park 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. 4 Donation 5 ☐ Other (Specify) 3-1-2008 Elkridge Maryland 21. Signature of Name al Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Uraine MIXEL MULLERian months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Die to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical E FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 M No 4□Pregnant at time of death 9□Unknown Month Day Year signed by the a 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 06 aremon 3(A) Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rector, page 2 s autonsy 2 No 1□ Yes 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death funeral 28a. Date of Injury 28b Time of 28d. Describe how injury occurred After (Month, Day Year) 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3∏ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: s after decrail After al Director: After the form filled in by within 24 hours a

To the Funeral I

completely filled

Registrar

Medical

31. Date filed (Month, Day, Year) State

29a. Certifier

(Check only one)

29b. Signature and title of certifier



and manner stated.

(my

1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | For State Registrar | State of Mar | • | epartment of Certificate of | | | g. No. 2 A A S | 05424 | | |
|-------------------|--|----------------|---|---|--------------------------------|--|---|---|--|--|--|--|
| - | Physicia | an | 1. Decedent's Name (First, Middle, L | | | | | 2. Date of Death Month | Day Year | 3. Time of Death 8:53 A M | | |
| | /Medic | al | Peter Depew Fisle 4a. Facility Name (If not institution, gi | | | 4h City Town | or Location of Death | | ruary 14, 2008 8:5 | | | |
| | Examin | Ç, | Holy Cross Hospit | | | | Spring | | Montgome | | | |
| - 1. | Funeral | | Social Security Number 6. | Sex 7. Age | (In yrs. last birth | | If Under 24 Hrs. | 8. Date of Birth (Month, Day, | Year) 9. Bir | thplace (State or Foreign ountry) | | |
| i. | Director | | 530-09-1/15 | 1 ∑ M 2□ F | 88 Y | rs. | Tiodio (Min. | Aug. 11, | | vada | | |
| | and w | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town | or Location | | | | 10d. Inside City Limits | | |
| | Maryl -f sho iied a | tor | Maryland Montgom | erv | Bethe | sda | | | | 1 □Yes 2XINo | | |
| | n the | ire | 10e. Street and Number | | | 10f. Zip Code | _ | | og. Citizen of What Co | | | |
| | 23a cust b | | 8036 Herb Farm Dr | | | 2081 | | | Jnited Sta | | | |
| | er der items ner m | Funeral | 11. Marital Status 1 ☐ Never Married 2 ☒ Married | 12. Was Decedent Ev Armed Forces? 1 X Yes 2 ☐ No | | 13. Was Decedent of If Yes, specify Cu | Hispanic Origin? (Sp ban, Mexican, Puert | pecify Yes or No- p Rican, etc.) | 14. Race - Ame Black, Whi | | | |
| 36 | urs aft al"; or xaml | ρ | 3 ☐ Widowed 4 ☐ Divorced | If Yes, Give Year or Dates: K | | 1 ☐ Yes 2 ☒ No | Specify: | | Specify: W | hite | | |
| 21215-0036 | 72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at | Completed | 15. Decedent's l | Education rade completed) | 16a. I | Decedent's Usual Occu (Give kind of work done life. DO NOT use retir | upation e during most of wor | king | 16b. Kind of Business | /Industry | | |
| 2 | within iene. than " | ld m | Elementary/Secondary (0-12) | College (1-4or 5+ |) | <i>life. DO NOT use retir</i> eneral Man | | I | Product Su | nn1v | | |
| р О | filed v Hygie other t | | 17. Father's Name (First, Middle, Las | | | eneral nam | 1 | ne (First, Middle, M | | PP+J | | |
| an | lid be lental ked o | To Be | Philip Comway Fis | ler | | | Vera De | pew | | | | |
| Maryland | ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygene. If item 27 is marked other than "natural", or items 23a or 28a-f show if item 27 is marked other than "natural", or items to notified at or other traumatic event, the Medical Examiner must be notified at | | 19a. Informant's Name/Relationship Jean Bauer Fisler | 1,77 | | Mailing Address (Stree | | | | | | |
| | is 1 and 2 in the strain a litem 27 is other train | | 20a. Method of Disposition | / wile | 20h Place of | Disposition (Name of | | Date | 20c. Location - City or | | | |
| altimore, | Pages nent of I ant: If its ury or o | | 1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec | | Arlingt | on Nationa emetery | April 200 | . 16, 08 A | rlington, | VA | | |
| aţį. | permit. Page Department of Important: If any Injury or once. | | 21. Signature - Funeral Service Lic | | l Ce | 22. Name and Add | | | umphrey Fu | neral Nome/ consin Ave. | | |
| <u>~</u> | an Dear | | 100/2 | SET. | | Bethesda, | Maryland | 20184 | | | | |
| | | | 23a. Part1. Enter the disease, or co shock, or heart failure. List on | mplications that caused t ly one cause on each line | he death. Do n | ot enter the mode of d | ying, such as cardiac | or respiratory arre | est, | Approximate Interval Between Onset and Death | | |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a Aspirati | | | | | | | | |
| | Examiner | | | Due to (or as a | consequence o | 1): | | | | | | |
| | | ner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a | consequence o | f): | | | | | | |
| | and // | Examine | Cause (Disease or injury that initiated events resulting in death) Last | c. Sepsis | consequence o | 41. | | | | | | |
| 68760, | ficate be executed physician and is the burial-transit | al E | , sooming in adding and | Due to (or as a | consequence o | 17. | | | | | | |
| 687 | ificate p phys | edical | | d | | | | | | | | |
| Box | death certif e attending d for use as | M/U | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome p 1□Live birth 2 | | 3 □Ectopic pregnar | ncv | | 23d. Date of delivery | | | |
| | 0 0 | Physician/M | in the past 12 months? 1 ☐ Yes 2 ☐ No | 4□Pregnant at t | | 5 ☐ Other (specify) | | | Month | Day Year | | |
| P.0 | that the de led by the a detached | | 9 Unknown Part II. Other significant conditions | s contributing to death but | t not resulting in | the underlying cause of | given in Part I. | 23e. Did tol | bacco use contribute | to the cause of death? | | |
| ds, | 8 5 8 | d by | • | | | | | 1 🗆 Y | es 2 X ∏No 3∏F | Probably 4 □Unknown | | |
| or Vital Records, | w require been significants | Completed | | | | | | 24a. Was a | n 24b. Were | autopsy findings available completion of cause of | | |
| æ | The law ate has b page 2 st | mo. | | | | | | autops perfor | med? death? | es 2 No | | |
| ita | slclan: Th certificate rector, pag | Be C | 25. Was case referred to medical examiner? | 1 | | | | ath Check onl on | | | | |
| ٥٢ / | Physthis aldi | 은 | 1 ☐ Yes 2 ☐ No 27. Manner of Death | Hospital: 1 Inpatien | t 2 ☐ ER/Out | patient 3 DOA | | | ence 6 Other (Sp | pecify) | | |
| on | ding h. After fune | tion: | 1 X Natural 5 □ Pending 2 □ Accident investigat | (Month, Day | | njury W | ork? □Yes 2□No | 20d. Describe III | d. Describe how injury occurred | | | |
| Division | or Attending after death. Director: After in by the fune | ifica | 3 Suicide 6 Could not 4 Homicide determine | be 28e Place of injur | ry - At home, far (Specify) | m, street, factory, offic | e | 28f. Location (Si City or Town | on (Street and Number or Rural Route Number, | | | |
| Ö | Ital or Ital o | Certification: | | | | | | | | | | |
| | To the Hospital or within 24 hours after To the Funeral Director Completely filled in the | Medical | 29a. Certifier 1 CertifyIng (Check only 2 Medical E) | Physician: To the best on caminer: On the basis of and manner state | examination and | , death occurred at the d/or investigation, in m | time, date and plac y opinion, death occ | e, and due to the our urred at the time, o | cause(s) and manner address and d | as stated. ue to the cause(s) | | |
| | To the within 2 To the comple | Med | 29b. Signature and title of certifier | and manner state | leu. | 29c. Lice | nse number | 2 | 29d. Date signed (Mo | | | |
| | ⊢ ≯ ⊨ ŏ | | 1 h | √ | | D659 | 53 | | February | 14, 2008 | | |
| | 12+1 | | 30. Name and address of person wi | | | | 2.13 | | m 00010 | | | |
| | | | Adaku C. Onu Kogi | 1, M.D., 150 | | t Glen Rd. | , Silver | Spring, | MD 20910 | | | |
| | Sta | ate | 31. Date filed (Month, Day Year) | 198 . negistra | . 3 Signature | 356 | | | | | | |

DHMH 17 Rev 1/2001

| | | | For State Registrar | State of | Marylar | - | | nt of H | | | lental Hy | gient | _000 | } | 05425 |
|-------------------|--|------------------|---|---|-----------------------------------|----------------------------------|-------------------------|----------------------------|------------------------------|---|-----------------------------------|-------------------------|----------------------------------|-------------------|--|
| | | | Decedent's Name (First, Middle, La | ist) | | | | | | | 2. Date of D | | - | - | 3. Time of Death |
| | Physici | an | Margarot Ann Cunthor | | | | | | | Month 0.2 | | | | | 14.50 PM |
| 0 | /Medio | | | | hael | | 45 01 | . Town or | Location | of Dooth | 02 | 15 | 7 201 County of D | | 11.0-1 |
| | Examin | ier | | acility Name (If not institution, give street and number) 4b. City, Town, or Loca | | | | | | | | | | | |
| | | | Harford Memorial | | | t 1 () at 1 1 1 | | re de | Gra | | 0.5 | | larford | | (0)-1 |
| | Funeral | | | Sex 7 1 □ M 2 💢 F | , | . last birthday) Yrs. | Month: | | Hours | Min. | 8. Date of B | ay, Year) |) | Coun | . * * |
| | Director | | 219-18-0399 | - 11 | 83 | 113. | | | | _ | 07-10- | -1924 | - Ma | ry. | Land |
| | pug * | | Usual Residence of Decedent 10a. State 10b. County | | 10c. C | ity, Town or Lo | cation | | | | | | | 1 | 0d. Inside City Limits |
| | sho | 5 | | | | | | | | | | | | | 1 □ Yes 2 🕅 No |
| | 889-f | ct | Maryland Harford | | I | Bel Air | | | | | | | | | |
| | or 2 | 100 | 10e. Street and Number | | | | | ip Code | | | | 10g. Ci | tizen of What | Coun | try? |
| | 23a | Funeral Director | 902 Jessica Lane |) | | | 2 | 1014 | | | | U.S | 5.A. | | |
| | ep E | ne | 11. Marital Status | 12. Was Deced | ent Ever in Ues? | J.S. 13. | Was Dec | edent of H | ispanic Or In, Mexica | rigin? (Sp | ecity Yes or N Rican, etc.) | 0- | 14. Race - A Black, W | | |
| 9 | or it | F | 1 Never Married 2 Married | 1 ☐ Yes 2 If Yes, Give | X No | | | 2X No | Specify. | | , , , | | Connik | | |
| 8 | ours raf', | d by | 3X Widowed 4 □ Divorced | Year or Dat | | | | 1,10 | | | | | Specify. W | Jhi | te |
| 21215-0036 | be filed within 72 hours after death with the Maryland nat Hygiene. ad other than "natural", or itema 23a or 28a-f show event, the Medical Examiner must be notilied at | Completed | 15. Decedent's E (Specify only highest gr | | | 16a. Dece | dent's Us | ual Occup | ation du <i>ring m</i> os | st of work | ina | 16b. K | (ind of Busine | ss/ind | dustry |
| 2 | within ene. then | ğ | Elementary/Secondary (0-12) | College (1- | for 5+) | life. | DO NOT | rork done d use retired | 1) . | | | | | | |
| 2 | iw po en the man | Ö | 12 | | | Home | mak | er | | | | Own | Home | | |
| g | e file | Be (| 17. Father's Name (First, Middle, Las | • | | | | | 18. Moth | er's Nam | e (First, Middle | e, Maider | n Sumame) | | |
| <u>a</u> | should be nd Menta marked matic ev | 2 | CLifford Dashiel | .1 | | | | | Eu. | la Co | ook | | | | |
| Maryland | | | 19a. Informant's Name/Relationship | Type, Print) | | 19b. Mailir | ng Addre | ss (Street | and Numb | er or Run | al Route Numi | ber, City | or Town, State | e, Zip | Code) |
| Ž | D = 2 1 | | William C. Gunth | er. Jr. | (Son) | 2220 | Per | rvman | Rd . | Aber | deen, M | m 21 | 001 | | |
| อ์ | s 1 and 2 f Health item 27 l | | 20a. Method of Disposition | | 20b. | Place of Dispo | sition (N | ame of | | | Date | | ocation - City | or To | wn, State |
| ᅙ | nt of nt of nt of | | 1 Burial 2 X Cremation 3 | | ate | cemetery, crei | , | • | | | 0000 | L 58 | | | |
| Ę | entmen entmen ortant: injury | | 4 □ Donation 5 □ Other (Special Service 3 Ser | _ | Ва | yview (| | | | Name (No. of Str. 100, 100, 100, 100, 100, 100, 100, 100 | -2008 | Bay | view C | ren | atory |
| Baltimore, | permit. Pages Depertment of H Important: If ite any injury or of | | 21. Signature y Fundral Service 366 | nsor | | | | and Addres | | Sci | | | | | of Bel Air |
| _ | du z e d | | 7000 | 9 | | | | | | | il Rd E | | ir, MD | 2 | |
| | | | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximately a such as cardiac or respiratory arrest, interventions of the cardiac or respiratory arrest. | | | | | | | | | | | | Approximate Interval Between |
| | Physician | ř i | Immediate Cause (Final disease or condition _ a _ Strepto co ccrus Agalacticae Group-B bacterental | | | | | | | | | | d | Onset and Death | |
| | /Medical | | resulting in death) | | as a conse | | 10 | W IOCC | ., . | 0 | LUVI | 0 | | | 1 00 13 |
| | Examiner | | | Urosepsis / Preumendae sepsis | | | | | | | | | | 9 days | |
| | | ē | Sequentially list conditions, if any, leading to immediate | Due to (or as a consequence of): | | | | | | | | | | + | |
| 1.6 | uted Insit | 뒽 | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | ARE | . ARF/ Electrolytes distribuners. | | | | | | | | | | 9 days |
| - | al-tra | Examiner | that initiated events resulting in death) Last | Due to (o | r as a conse | | F | CV II | | | | | | | |
| 8760, | icate be executed physicien and s the burial-transit | a | l l | Dice | betes i | mellitu | 10 | Dor | neut | ra l | HITN | | | | 20-30 Yrs |
| 387 | cate phys | dical | | | | | | | | v - (| | | | | |
| 9 x | The law requires that the death certificate be execuied ite has been signed by the attending physicien and page 2 should be deteched for use as the burial-transit | Physician/Me | IF FEMALE: | 23c. If yes, outco | ome of prean | ancv | | | | | | | | م خامات | |
| Вох | ath catternate | lan | 23b. Was decedent pregnant in the past 12 months? | 1☐Live bir | th 2 🗆 Fet | al death 3[| | pregnancy | • | | | | 23d. Date of Month | Oelive | Day Year |
| Ö | to the de by the a teched to | sic | 1 ☐ Yes 2 No 9 ☐ Unknown | 4⊟ Pregna 9□ Unknov | nt at time of o vn | death 5L | Other (| sреспу) _— | | | | | | | |
| P.0 | that the ed by detect | Ph | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | | | | | oga Did | 400.000 | | - 1- 1 | e cause of death? |
| Ś | res tha igned be de | Ď | Part II. Other significant conditions | contributing to dea | ith but not res | sulang in the u | noenying | cause give | en in Part | 1. | 1 | | / | | |
| of Vital Records, | w requir been s should | Completed | | | | | | | | | 11_ | Yes 2 | es 212 No 3 Probably 4 Unknown | | |
| Š | aw r | ple | | | | | | | | | 24a. Wa | | 24b. Were | auto | psy findings available inpletion of cause of |
| æ | The lay | E | | | | | | | | | per | opsy formed? | death | 1? | 2DNo |
| | | | 25. Was case referred to medical | | | | | | 26 Place | o of Dost | 1 ☐ Yes | | 0 101 | 93 | 202110 |
| 5 | sician: certific lirector, | o Be | examiner? 1 ☐ Yes 2 No | Hospital: | patient 2 | ER/Outpatier | nt 3□ [| Oth | 00 | | me 5□Res | | 6 DOther (6 | 2000 | .1 |
| of | Phys rahis rahdi | . To | 27. Mannet of Death | | | 28b. Time o | | | | ursing no | 28d. Describe | | | pecin | <u>'</u> |
| n | ding I h. After funer | Į. | 1 ⊠Natural 5 ☐ Pending | (Month, Day Year) Injury | | | М | 28c. Injun Work | k? Yes 2⊡ | No | | | , | | |
| Division | ial or Attendii s after death. al Director: Al ad in by the fu | Certification: | 3 ☐ Suicide 6 ☐ Could not I | e One Diese | f Injuny - At h | nome, farm, str | | | | | 28f Location | (Stroot 2 | nd Number or | r Dum | l Route Number, |
| .≥ | or A lifter Sirect in by | Į. | 4 Homicide determined | building | g, etc. (Speci | ify) | eel, lack | жу, опсе | | | | own, Stat | | 71070 | r riodte i variber, |
| _ | ors surs surs surs surs surs surs surs s | | 00.0.00 | | | | | | | | | | | | |
| | To the Hospital or Attending Physician: within 24 hours after death: To the Funeral Director: After this certific completely filled in by the funeral director, | Medical | (Check only 2 Medical Exa | hysician: To the b miner: On the bas | is of examin | owledge, deat ation and/or in | n occurre vestigatio | d at the timen, in my or | ne, date ar pinion, dea | nd place, ath occur | and due to the red at the time | e cause(s e, date an | s) and manner id place, and r | r as si due to | ated. the cause(s) |
| | the. I the I | led | one) | and manne | er stated. | | | | | | | | | | |
| | Viit Con Con | | 29b. Signature and title of certifier | 40.01 | MI |) | | 9c. Licens | | c,, , | . | | ate signed (M | | |
| | | | ▶ Kamal Ban | rejuria_ | 141. |) 0 | | D00 | 65 6 | 41 | | Febr | ruary : | 18, | 2008 |
| | 17 | | 30. Name and address of person who | completed cause | of death (Ite | m 23a) (Type, | Print) | | 200 | | Dalas | , , | 100 01 | 101 | 4. |
| | N | | KAMAL G. BA | NGORIA | 500 | m 23a) (Type.) Upper | che | sapece | ke el | nove | Belai | 2 | NIN XI | 01 | 7]- |
| | Sta | te | 31. Date filed (Month, Day, Year) | | gistrar's Sign | ature | 8 | | | | | | | | |
| | Registr | | rep o o | 2002 | | No sale | and | and it | | | | | | | |

GUNTHER, MARGARET

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 45 Gershi 202008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Jewish Convalescent Home Baltimore Baltmore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Hours Months Days Min 1 □ M 2√□ F Yrs. 062-09-7516 101 Dec 8, 1906 Canada Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4923 Clearwater Drive 21043 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed)

Admin<u>istrative Work</u>

Sykesville, MD 21784

other traumatic event, the Medical Exerciner must be notified at Baltimore, Maryland 21215-0036 ŏ "natural" 2 should be f and Mental H is marked of permit. Pages 1 and 2 sho.
Department of Health and M.
Important: If item 27 is meany injury or other.

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

10a State

MD

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

Louis Cohn

21. Signature of Funeral Service Licensee

19a. Informant's Name/Relationship (Type, Print)

Mrs. Barbara Cohn (Niece)

1 Burial 2 Termation 3 Removal from State
4 Donation 5 Other (Specify)

10

20a Method of Disposition

Funeral

Director

Physician /Medical Examiner

use as the burial-transit

led by the attending physician and deteched for use as the burial-tran

Physician/Medical

3

Completed

2

Certification:

Medical

State Registrar

Gers h tento be

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine

Immediate Cause (Final disease or condition resulting in death)

23a. Part1. Enter the disease, or comp shock, or heart failure. List only of

| ne d | cause on each line. |
|------|----------------------------------|
| a | acute procesdial inferit |
| | Due to (or as a consequence of): |
| b | Coslee anthy me |
| | Due to (or as a consequence of): |
| c. | Cerys & we Hest Jul |
| | Due to (or as a consequence of): |
| | |

20b. Place of Disposition (Name of cemetery, crematory or other place)

Approximate Interval Between Onset and Death 7 WIN

18. Mother's Name (First, Middle, Maiden Sumame)

HATCHT FUNERAL HOME & CHAPEL, P.A. (Box 195)

Sarah (unknown)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4923 Clearwater Dr. Ellicott City, MD 21043

All County Cremation 2/22/2008 | Sykesville, MD

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown

25. Was case referred to medical

5 Pending

Main

investigation 6 Could not be determined

1 ☐ Yes 2 Wo

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

College (1-4or 5+)

4 Pregnant at time of death 9 Unknown

M00764

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Miknown

Clerical

20c. Location - City or Town, State

Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed? 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Hospital: 1 🗌 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other 4 ursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

examiner'

27. Manner of Death

Natural 2 Accident

3 Suicide

4 Thomicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

Tight Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

al or Attending Patter death. After

To the Hospital within 24 hours a To the Funeral C

31. Cate filed (Month, Day, Year)

32. Registrar's Signature



2434

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 18, 2008 4:15 Lorna B. Griffin /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Bethesda Carriage Hill If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕅 F 91 578-32-2008 January 16, 1917 New York Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits r 28a-f show notified at 10c. City. Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director Chevy Chase Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be 8901 Kensington Parkway United States 20815 Funeral 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 11. Marital Status filed within 72 hours after 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify þ 3X Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ath and Mental Hygiene.
27 Is marked other than "r
r traumatic event, the Med College (1-4or 5+) Elementary/Secondary (0-12) Own Home 4 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Zillah Tainton Ernst Pottberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health ar
Important: If Item 27 Is
any injury or other trau 8901 Kensington Parkway, Chevy Chase, Maryland 20815 Bryan F. Griffin/ Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) n Memorial Park 23, 2008 Rockville, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 February Parklawn Memorial Park 21. Signature of Funeral Service Licenses Wisconsin Avenue M00335 M00335 | Bethesda, Maryland 20814-350

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Physician /Medical Due to (or as a consequence of): Examiner Chronic Ostructive Pulmonary Disease Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine death certificate be executed burial-transi Pneumonia Due to (or as a consequence of): Box 68760. Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 📉 No 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28d. Describe how injury occurred 28b. Time of Certification: 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No ie Hospital or Attendi 24 hours after death. ie Funeral Director: A death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

20

DHMH 17 Rev 1/2001

To the I within 2

State

29a. Certifier (Check only one)

29b. Signature and title of certifier

wommes

Thomas V. Joseph, M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSUND

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0047330

50 West Edmonston Drive #207 Rockville, Maryland 20852

29d. Date signed (Month, Day, Year)

February 19, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| onald Goldstein | 1- For State | Certificate of Death | Reg. | 2008 0 <u>542</u> |
|--|---|--|--|---|
| Physician/ | | COLDCTEIN | 2. Date of Death Month D. February 17, | 3. Time of Death |
| ledical Examine | RONALD 4a. Facility Name (if not institution, give street and number) | GOLDSTEIN [4b. City, Town, or | | 4c. County of Death |
| | Sinai Hospital | Baltimore C | ty | N/A |
| Funeral | o. Coolar Cocarry Name | (In yrs. last birthday) If Under 1 Year Months Days | | MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD |
| Director | 220-52-5745 | 56 Yrs. Wallats 33/5 | 03/10/1 | .931 Godinayy 110 |
| any | 10a. State 10b. County | IOc. City, Town or Location | | 10d. Inside City Limits 1 X Yes 2 No |
| Aaryland 28a-f show 1 at once. ector | MD N/A | BALTIMORE 10f. Zip Code | 1100 | Citizen of What Country? |
| the Maryland to 28a-f sh | 10e. Street and Number 3310 RUECKERT AVENUE | Tot. Zip Gode | 21214 | USA |
| ath with the Maryland items 23a or 28a-f sho | 11. Mantal Status 12. Was Decedent I | Ever in U.S. 13. Was Decedent of His | panic Origin? (Specify Yes or No- , Mexican, Puerto Rican, etc.) | 14. Race - American Indian, Black, White, etc. |
| r death or iten | 1 Never Married 2 Married 1 X Yes 2 | No 1 Yes 2 X No | | Specify: WHITE |
| urs after turaf", miner | 3 N Widowed 4 Divolced or Dates: | | ion (Give kind of work done | 6b. Kind of Business/Industry |
| 6 172 hou an "nai cal Exs | Elementary/Secondary (0-12) College (1-4 or 5 | +) CARPENTER | DO NOT use retired) | CARPENTRY |
| 21215-0036 Muld be filed within 72 hours after death with the Maryland Mental Hygeine. marked other than "natural", or items 23a or 28a-f she ic event, the Medical Examiner must be notified at once To Re Compileted by Finneral Director | 12 17. Father's Name (First, Middle, Last) | | 18.Mother's Name (First, Middle, Ma | |
| 21215 21215 Wental Hy marked o | HYMAN | GOLDSTEIN | ETTA et and Number or Rural Route Numb | ALDRIDGE er City or Town State Zin Code) |
| Shoul shoul and N 7 is m | 19a. Informant's Name/Relationship (Type, Print) KATHLEEN BREWER / NIECE | 3310 RUECKE | RT AVENUE, BALTI | MORE, MD 21214 |
| - Page a | 20a. Method of Disposition | 20b. Place of Disposition (Name of ce crematory or other place) | | 20c. Location - City or Town, State |
| Baltimore, Peges 1 a Department of He Important: If it injury or other to injury or other to the tenter to the ten | 4 Donation 5 Other Specify: | IRACITMOKE DEDKEM | | BALTIMORE, MD ON & BROS., INC. |
| Baltimo permit. Page. Department o Important: injury or oth | 21. Signature of Funeral Service Licensee | 8900 REIS | STERSTOWN RD., PI | KESVILLE, MD 21208 |
| Physician | 23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line. | | | st, shock, or heart Approximate Interval Between Onset and |
| /Medical aminer | Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Due to (or as a const | Cardiovascular Disease | | Death |
| M | Sequentially list conditions. b. | | | |
| | if any, leading to immediate cause. Enter Underlying Cause c. | | | |
| * # | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consider) Due to (or as a consider) | equence of): | | |
| 50, te be executed ysician and burial - tran it | d. UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome and the second of | | | |
| 760, icate be physic the bur | IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant in the | | Ectopic pregnancy | 23d. Date of delivery Month Day Year |
| Box 68760, e death certificate be the attending physic ed for use as the bur | past 12 months? | time of death 5 Other (Specify) | | |
| the deal by the all ched for | 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to deal | h but not resulting in the underlying cause | \$ | bacco use contribute to the cause of death? |
| P.O. es that the signed by be detac | à | | 1 Yes | 2 No 3 Probably 4 ✔ Unknown |
| ords, v requires s been s should | ompleted | | 24a. Was a autop: | sy prior to completion of cause of |
| Recc The lav | Comp | | 1 Yes | 2 No 1 Yes 2 No |
| ician: s certifi | o 25. Was case referred to medical examiner? Hospital: | ent 2 ✓ ER/Outpatient 3 DOA | Other Nursing Home 5 | Residence 6 Other: |
| Division of Vital Records, ra or Attending Physician: The law requirers after death. "al Director: After this certificate has been sided in by the funeral director, page 2 should be an in by the funeral director, page 2 should be a second to be | 27 Manner of Death 28a Date of Inc | | | now injury occurred |
| sion ttendib death. ctor: | Natural 5 Pending Investigation | njury - At home, farm, street, factory, office | Yes 2 No 28f Location (\$ | Street and Number or Rural Route Number, City |
| Divis | To Natural 5 Pending Investigation 28e. Place of Investigation 4 Homicide determined (Specify) | njury - At home, fami, sileet, factory, onto | or Town, S | |
| hou ner | | ny knowledge, death occurred at the time, | date and place, and due to the caus | e(s) and manner as stated. and place, and due to the cause(s) |
| To the comple | Check only one) 2 Medical Examiner: On the basis of exand manner states 29b. Signature and title of certifier | · | nse number | 29d. Date signed (Month, Day, Year) |
| | PI D POOD | h his o.c | C.M.E. | February 18, 2008 |
| | 30. Name and address of person who completed cause of | | Street, Baltimore, MD 2120 | 1 |
| | A 20 Pogist | Medical Examiner 111 Penn ar's Signature | Outer, Dalimore, MD 2120 | |
| Sta Registi | TED 0 4 2000 | K Ames | | |

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2.0.0.9

| | | | 1 - For State Registrar | | , | Certific | ate of D | eath | | JieneZUUZ | 03423 | | |
|------------|--|---|---|--|--|------------------------------------|--------------------------------------|--|--|--|---|--|--|
| | Physici | an | 1. Decedent's Name (First, Middle, La | idie, Last) | | | | | | th Day Year | 3. Time of Death | | |
| | /Medi | | Janet M. Gindell | | | | Februar | ry 7, 2008 | 4:50 AM M | | | | |
| 7 | Examir | er | 4a. Facility Name (If not institution, giv 8735 Piney Orcha | | | | Sity, Town, or L Odentor | ocation of Death | 4c. County of Dear | | | | |
| | Funeral | | 5. Social Security Number 6. S | | ge (In yrs. last bi | irthday) If Ui | nder 1 Year | If Under 24 Hrs. | 8. Date of Birth | | hplace (State or Foreign | | |
| | Director | | 195-16-3875 Usuel Residence of Decedent | □M 2\XF | 84 | Yrs. Mon | ths Days | Hours Min. | 8. Date of Birth (Month, Day June 8, | 1923 Peni | nsylvania | | |
| | yland yland | | 10a. State 10b. County | | | 10d. Inside City Limits | | | | | | | |
| | r 28a-f ehow | ctor | MD Anne Ar | unde1 | | Oden | ton | | | | 1 ☐ Yes 21 No | | |
| | with the | Funeral Director | 10e. Street and Number 10f. Zip Code 10g. Citize 8735 Piney Orchard Parkway 21113 | | | | | | | | ountry? | | |
| | deeth w | eral | 11. Marital Status | 12. Was Decedent | | 13. Was Di | | | ecify Yes or No- | USA 14. Race - Ame | erican Indian | | |
| 21215-0036 | hours after deeth with the Maryland tural', or flems 23a or 28a-f ehow al Examinar must be notified at | þ | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ② Divorced | Armed Forces: 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: | • | | specify Cuban, | panic Origin? (Sp Mexican, Puerto Specify: | Rican, etc.) | Black, Whit | e, etc. | | |
| 5-0 | "natural", | etec | 15. Decedent's Ed (Specify only highest gra | lucation de completed) | 16a | Decedent's U | Jsual Occupati work done du | on ring most of work | ing | 16b. Kind of Business | Industry | | |
| 121 | within ane. then | Completed | Elementary/Secondary (0-12) | College (1-4or | 5+) | life. DO NO | Tuse retired) | , | | retai: | 1 | | |
| d 2 | Hygie Hygie other | ပိ | 17. Father's Name (First, Middle, Last) | U | | | 1 | 8. Mother's Nam | e (First, Middle, i | Maiden Sumame) | | | |
| lan | Mental Mental rked c | To Be | Clarence Clyde W | olfe | | | | Ma | | | | | |
| Maryland | ind 2 shou alth and N 27 ie mai | | 19a. Informant's Name/Relationship (Heart Homes Ass | | 198 | o. Mailing Add | ress (Street an | d Number or Run hard Pkv | y Odent | umber, City or Town, State, Zip Code) enton, MD 21113 | | | |
| Baltimore, | permit. Pages 1 end 2 should be filed within 72 ho Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natur any injury or other traumatic event, the Medical 2006. | | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Specification of the content o | | 20b. Place of cemete | of Disposition (ery, crematory | (Name of or other place) | | Dete | 20c. Location - City or | Town, State | | |
| Balt | permit. Depertrimports any inju | | 21. Signature of Funeral Service Licer Ronald S. | Wade, Dir | ector | | and Address Anator | | 1655 W. | Baltimore | Street | | |
| | | | 23a. Part1. Enter the disease, or com shock, or heert failure. List only | olications that caused | the death. Do | | | | | | Approximate Interval Between | | |
| | Physician | | Immediate Cause (Final disease or condition | F | -maly | Awa | | | | | onsat and Death | | |
| | /Medical Examiner | | resulting in death) Due to (or as a consequence of): | | | | | | | | | | |
| | LXdiffiller | 2 | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): | | | | | | | | | | |
| | nsit | nlne | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | or). | | | | | | | | | |
| Ć, | execu an and ial-tra | Examiner | resulting in death) Last Due to (or as a consequence of): | | | | | | | | | | |
| 68760, | tificate be executed g physicien and as the burial-transit | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Yes 2 Yes 2 No 9 Unknown Yes 2 Yes 2 No 9 Unknown Yes 2 | | | | | | | | | | | |
| % 68 | entifica ling ph e as t | Med | IF FEMALE: | | | | | | | | | | |
| Вох | leath cer attendin I for use | lan/ | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome 1☐Live birth 4☐Pregnant a | | | 23d. Date of del Month | 23d. Date of delivery Month Day Year | | | | | |
| P.O. | that the dended by the a | ysk | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 9□Unknown | time or death | 5 Cother | (ѕреспу) | | | | | | |
| S, | The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit | by P | Part II. Other significant conditions o | ontributing to death b | ut not resulting i | n the undertyin | ng cause given | in Part I. | 23e. Did tot | pacco use contribute to | the cause of death? | | |
| Records, | w requir been si should | ted | | · | | | | | 1 □ Ye | es 2 No 3 Pr | obably 4 Donknown | | |
| Sec | e law has b | Completed | | | | | | | 24a. Was a autops | y prior to | topsy findings available completion of cause of | | |
| a | r: The | | | | | | | | perform 1 Yes 2 | ned? death? | 30 Mg | | |
| Vital | Physicien: r this certificatal director, I | o Be | 25. Was case referred to medicat examiner? 1 Yes 2 No | Hospital: | - ACI CD/O | | 04 | 26. Place of Deatl | | | Akylol | | |
| of | Phy er this eral d | n: To | 27. Manner of Death | 1 ☐ Inpatie 28a. Date of Inju (Month, Da | | utpatient 3 Time of | 28c. Injury a Work? | 4 Nursing Ho | | ence 6 Other (Specow injury occurred | city) IVIV | | |
| ion | Attending in death. actor: After by the fune | atlo | 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation | (Month, Da | y Year) | Injury M | | s 2 No | | | | | |
| - | al or Atte s efter de il Directo id in by th | Certification: | 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Num City or Town, State) | | | | | | | | ural Route Number, | | |
| | To the Hospital or Attending Physicien: The within 24 hours efter death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page | Medical | 29a. Certifier (Check only one) Medical Exam | ysician: To the best iner: On the basis o and manner sta | of my knowledge f examination an ated. | e, death occur id/or investigat | red at the time, tion, in my opin | date and place, ion, death occurr | and due to the ca ed at the time, da | ause(s) and manner as ate and place, and due | stated. to the cause(s) | | |
| | To the To the comp | ž | 29b. Signature and title of portifier | T. Kin | | | 29c. License n | number | | 9d. Date signed (Monti | h, Day, Year) | | |
| | | | > keey | 112 | | | D | 20044 | · | 415/01 |) | | |
| | | | 30. Name and address of person who | empleted cause of d | / / / | (Type, Print). | ruden | n Pak | Orur | Alla Burin | e Wash | | |
| | Sta | e | 31. Date filed (Month, Day, Year) FFB 2 2 200 | 32. Registr | ar's Signature | death. | | | | 30/-//[| 4,00) | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For State Registrar | State of Ma | arylan | | artmen rtificate | | | | lental Hy | gien Reg. N | 0000 | 05430 |
|----------------------------|---|----------------|--|---|-----------------|------------------------|--------------------------|-------------------------|--------------------------|---------------------|---------------------------------|----------------|---------------------------------|--|
| | Physici | an | 1. Decedent's Name (First, Middle, Last, | | | | | | | | 2. Date of De Month | D | ay Year | 3. Time of Death |
| | /Media | cal | ALBERTA ANN GIAN | | | | 4h (Cib.) | Town or | Location of | of Dooth | FEBRUA | - | 18, 2008 c. County of Deat | 4:00 P M |
| | Examir | ner | 4a. Facility Name (If not institution, give 403 Oak Street | street and number) | | | 7, | ewoo | | Di Deau | | 7 | Harford | |
| | Funeral | | 5. Social Security Number 6. Se: | | e (In yrs. | last birthday) | If Under | 1 Year | If Under | | 8. Date of Bit (Month, Da | rth | 9. Birt | nplace (State or Foreign untry) |
| | Director | | 218-52-1062 |]M 2 ⊠ F | 59 | Yrs. | Months | Days | Hours | Min. | June 1 | 8, 3 | 1948 Pen | nsylvania |
| | pug * | | Usual Residence of Decedent 10a. State 10b. County | | 10c. Cit | y, Town or Lo | cation | | | | | | | 10d. Inside City Limits |
| - | Maryland I show | ŏ | Maryland Harford | | | gewood | | | | | | | | 1 ☐ Yes 2X No |
| \leq | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | Director | 10e. Street and Number | | 1 1.00 | gewood | 10f. Zip | Code | | | | 10g. C | Citizen of What Co | untry? |
| Tian Lir | 23a o | a D | 403 Oak Street | | | | 21 | 040 | | | | USZ | A | |
| 5 | - dea | Funeral | 11. Marital Status | 12. Was Decedent Armed Forces? | | .S. 13.\ | Was Deced | lent of Hi | spanic Ori n, Mexicar | igin? (Spen, Puerto | ecify Yes or No Rican, etc.) | 0- | 14. Race - Arne Black, White | |
| ့် ဗွ | s afte | by Fi | 1X Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 2 1 If Yes, Give Year or Dates: | No | | 1 □ Yes | No No | Specify: | | | | Specify: | White |
| 5-0036 | ture! | ed | 15. Decedent's Edu | | | 16a. Deced | dent's Usua | I Occupa | ation | | | 16b. | Kind of Business/ | |
| 215 | hin 72 Pr. "na Me Ji | Completed | (Specify only highest grad | (1-4or 5 College | 5+) | (Give | kind of wor DO NOT us | rk done d se retired | during mos) | t of work | ing | | | |
| 2 | ed wit | Con | | 4 | | Regis | tered | Nur | | | | | alth Car | 9 |
| la la | be file | Be | 17. Father's Name (First, Middle, Last) Albert Frank Giann | ini Cr | | | | | | | e (First, Middle Dara Cl | | | |
| ದ Maryland | hould d Mer marke matic | T _o | 19a. Informant's Name/Relationship (T) | | | 19b Mailir | na Address | (Street a | | | | | or Town, State, 2 | In Code) |
| ಭ ≅ | Ith an 27 ie r | | Albert F. Giannin | | | | 5 | | | | | 355.0 | aryland | |
| 4.5 | s 1 ar | | 20a. Method of Disposition | | 20b. F | Place of Dispo | sition (Nan | ne of | 1 | | Date | | Location - City or | |
| A E | Page nent c ant: If ary or | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) | | | lltop | _ | | | 2-2 | L-08 | To | wson, Ma | ryland |
| Albert Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygione. Important: if item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other treumatic event, the Medical Exacting Iranal Rescription and Once. | h | 21. Signature of Funeral Service Licens | 500 | | 22 | Name an | d Addres | s of Facili | ¥1 Ho | ome, P. | Α. | | |
| 2 m | 40 E B 0 | | 23a. Part1. Enter the disease, or compl | eigh | | | 1317 | Coke | sbury | z Roa | ad, Abi | ngd | on, Mary | land 21009 Approximate |
| | | | shock, or heart failure. List only o | ne cause on each li | ne. | th Do not ent | er the mod | eroronym / | . 1 | , | or respiratory a | arrest, | | Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | a Due to (or as | 16 | Juence of): | Ma | 1 | lufe | WC 7 | 200 | | | 1 day |
| | Examiner | | | . Due to (or as | HI | Ano 5 | cler | Shic | 12 | dive | 19cula | Cles | 5C1, C 10 | bear |
| | THE . | je | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (or as | onsed | quence of): | 11 | 1 | 1.10 | φ. σ. | . ,,,,,,, | 0, - | Ste / C | 2 |
| | acuted tnd transi | Examiner | Cause (Disease or injury that initiated events resulting in death) Last | c | typ | revolut | es per | sler | nia | | | | | Lyeers |
| 760, | ite be executed yslcien and ne burial-transit | | resulting in death) cast | Due to (or as | a gorseo | quence of): | | | | | | | | |
| 687 | ete Ne | dical | | d | | | | | | | | | | |
| Box (| death certifical e attending phy of for use as th | Physician/Med | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome | | | | | | | | | 23d. Date of de | ivery |
| | 0 0 2 | icia | in the past 12 months? 1 ☐ Yes 2 ☐ No | 1□Live birth 4□Pregnant a 9□Unknown | | | Ectopic pr Other (sp | | | | | | Month | Day Year |
| P.O | at the by th | hys | 9 □ Unknown | | - | | | | | | | | | |
| | requires that the death een signed by the atte hould be detached for | 5 | Part II. Other significant conditions co | intributing to death b | out not res | sulting in the u | nderlying c | ause givi | en in Parti | ł. | | | | o the cause of death? obably 4 Unknown |
| oro | nee | eted | | 10010710 | | | | | | | - | | | |
| Rec | The law ste has b page 2 sh | Completed | , | | | | | | | | perf | opsy ormed? | death? | stopsy findings available completion of cause of |
| tal | in Ti | 0 | 25. Was case referred to medical | | | | | | 26 Place | e of Deat | 1 ☐ Yes | | No 1 ☐ Yes | 2□ No |
| <u> </u> | Physician: this certific ral director, | To B | examiner? | Hospital: 1 🗌 Inpatio | ent 2 | ER/Outpatier | nt 3 DC | Oth | on | ursing Ho | | | 6 ☐Other (Spe | cify) |
| 0 | ding Physician: The lav h. After this certificete has funeral director, page 2 | | 27. Manny of Death 1 Natural 5 ☐ Pending | 28a. Date of Inju (Month, Da | ıry ıy Year) | 28b. Time of Injury | 1 2 | 8c. Injun Worl | y at k? | | 28d. Describe | how in | jury occurred | |
| Sio | ttending death. stor: After the funer | catl | 2 Accident investigation 3 Suicide 6 Could not be | OD Diversities | | | M | | Yes 2 | No | ORI Language | (Cten nt | and Mumbas or D | and Courte Number |
| Division of Vital Records, | after of Direction by | Certification: | 4 Homicide determined | 28e. Place of fn building, et | | | reet, factor | , office | | | 28f. Location City or To | | | ural Route Number, |
| 80 | To the Hospitel or Attencyinin 24 hours after death To the Funeral Director: completely filled in by the | | 29a. Certifier 1 Certifying Phy | sician: To the best | of my kno | owledge, deat | h occurred | at the tin | ne, date ar | nd place, | and due to the | e cause | (s) and manner as | stated. |
| 1 | the Ho hin 24 the Fu | Medical | one) | iner: On the basis of and manner st | | ation and/or in | | | | ath occur | red at the time | | | |
| | To To | 2 | 29b. Signature and file of certifier | | .0 | | 290 | c. Licenso | number | 7- | | 29d. (| ate signed (Mont | h, Day, Year) |
| | | | 19/12 r | Po tok | Y | - 00-) 7 | D-i-t | 17- | >70 | 6 | | re | yury | 17 (008 |
| | | | 60 Name and address of person who c | Enal | Jean (Iter | 11 23a) (Type, | FINI) | Co. | Je. | Mr. | Fo | 60 | med Mr | 17 21040 |
| | Sta | ate | 31. Date filed (Month, Day, Year) | 32. Registr | rar's Signa | ature | 47 2 | | 7 | | | 7 | | |
| | Regist | rar | FEB 2 2 2008 | A SOLD BEAR | 1 | | S.A. | | | | | | | |

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 8 FEB Year 8:52 AM 2008 mes 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore N/A Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Min Months Hours 1 M 2 ☐ F 79 250-48-7004 29,1928 S.Carolina Usual Residence of Deceden and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene. m 27 is marked other than "natural", or Items 23a or 28a-f show m 27 is marked other than "natural", or Items 23a or 28a-f show her traumatic event, the Medical Exminier must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County Baltimore Y∏Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4936 Edgemere Avenue 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo Black þ Specify. Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Harry T. Campbell Elementary/Secondary (0-12) College (1-4or 5+) Construction Sons 6th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tom Horn ၉ Daisy Little 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 Health em 27 I 4936 Edgemere Avenue Baltimore, Maryland Mable Horne/Wife permit. Pages 1 and Department of Healt Important: If item 2 any injury or other 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Zion Cemetery 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 2/23/08 Lansdowne, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licenses 5240 Reisterstown Rd Baltimore, Md 21215 arr 23a. Part1. Enter the crease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fillure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Mal disease or condition resulting in death) **Physician** STROKE 24 HOURS /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine physician and requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AT2438946 M.13. FEB 18th 2008 1/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HINA GHAFOOR M.D. UNION MEMORIAL HOSPITAL IMD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FFR 2 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FEBRUARY 21 2:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARBOR IMORE BALT MOSP If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2 □ F 84 Director 07/18/1923 Maryland 217-18-9670 Usual Residence of Deceden permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Baltimore Director MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4438 Fenor Road 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1X() Yes 2 □ No If Yes, Give Year or Dates: 14. Bace - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 No Specify: \$ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreman/Public Works Dept. City of Baltimore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louis Hobbs Irene Ramsey ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie A. Smith (Pers. Rep.) 4438 Fenor Road, Baltimore, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removal from State Meadowridge Memorial 02/25/2008 Elkridge, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service Licensee Mark T. 2 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final ASPIRATION PNEUMONI) PNEUMONTA disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner RUCTIVE attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 □ Pregnant at time of death 9 □ Unknown 5 Other (specify) 1 Ves 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ON'S DISEASE 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No Be

Physician /Medical Examiner

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

After

the

completely

after death.

Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

25. Was case referred to medical examiner? Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🔀 No

28a. Date of Injury (Month, Day Year)

26. Place of Death (Check only one) Other: 4 \sum Nursing Home

5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death 1 X Natural

4 | Homicide

ပ

Certification:

Medical

5 Pending investigation 2 Accident 3 ☐ Suicide

6 Could not be

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28d. Describe how injury occurred 1 TYes 2 TNo

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28c. Injury at Work?

29b. Signature and title of certifier acres MEDICAL DOCTOR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DMITRI GAGARIN

29c. License number RESOOI

29d. Date signed (Month, Day, Year) FEBRUARY 21 2008

3001 SOUTH HANOVER STREET BALTIMOR 31. Date filed (Month, Day, Year)

FEB 2 2 2008



DHMH 17 Rev 1/2001

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

| | | | For State Registrar | State of | Marylan | | artment rtificate | | | and M | _ | gien Reg. N | 200 | 8 0 | 54 | 33 |
|-------------------|---|----------------|--|--|-------------------------------------|--------------------------------|----------------------------|------------------|----------------------------|-------------|------------------------------------|------------------------|--------------------------|----------------------------|------------------------------|------------------|
| | Physic | | 1. Decedent's Name (First, Middle Harry Huffman | , Last) | | | | | | | 2. Date of De Month | eath Da | ay Yea | ır | ime of D | |
| | /Medi Exami | | 4a. Facility Name (If not institution | , give street and numb | per) | | 4b. City, 7 | own, o | r Location o | | Februar | | 0, 200 | | 52 | AM |
| | | | 2831 Terrace I | | | | | | Chase | | | | Montgo | nery | | |
| В | Funeral Director | | 5. Social Security Number | 6. Sex 7. 1 ☑ M 2 ☐ F | Age (In yrs. | last birthday) Yrs. | If Under Months | Year Days | If Under Hours | Min. | 8. Date of Bir (Month, Da | ay, Yea <i>i</i> | 9. E | Birthplace (S Country) | | |
| | Tagin on the | | 223-46-7809 Usual Residence of Decedent | | 71 | | | | | | July 25, | 193 | 6 | Vi | rgi | nia |
| | arylan show d at | ī | 10a. State 10b. County | | 10c. City | y, Town or Lo | cation | | | | | | | 10d. Ins | | |
| | the Ma 28a-f | Director | Maryland Mont 10e. Street and Number | gomery | Ch | evy Ch | | | | | | | | |]Yes 2 | 2 ☆ No |
| | 3a or | Ö | 2831 Terrace I |)rivo | | | 10f. Zip (| 815 | | | | | tizen of What | • | | |
| | death | Funeral | 11. Marital Status | 12. Was Decede | ent Ever in U. | S. 13. | | | ispanic Ori | gin? (Spe | ecify Yes or No Rican, etc.) | | nited S 14. Race - Ar | nerican Indi | | |
| 98 | after or ite | | 1 ☐ Never Married 2 Marri | If Yes, Give | ⊠ No | | ır Yes, speci 1 ∐ Yes 2 | | an, Mexicar Specify: | i, Puerto i | Rican, etc.) | | Black, W | | | |
| 8 | hours tural" al Exa | ed by | 3 Widowed 4 Divorced | Year or Date | es: | | dent's Usual | | | | | 405.1 | Specify: \ | | | |
| 7. | nin 72 n "na n "na Medic | plete | 15. Decedent (Specify only highes Elementary/Secondary (0-12) | s Education st grade completed) College (1-4 | 5.) | (Give | kind of work DO NOT use | done de retirea | ation during mosi f) | t of workii | ng | 16b. F | (ind of Busines | ss/Industry | | |
| 212 | ed with /giene er tha er the | Completed | 8 | College (1-40 | or 5+) | | Pai | nte | r | | | | Paint | ing | | |
| pur | be file of oth event | Be | 17. Father's Name (First, Middle, I | , | | | | | 18. Mothe | r's Name | (First, Middle, | , Maidei | Surname) | | | |
| Ž | thould ind Mei marke matic | 은 | Unknown 19a. Informant's Name/Relationsh | Huffman | | 19h Mailir | an Addross (| Stroot | | isy | l Route Numb | | known | 7: 0 | | |
| Ma | nd 2 salth an 27 is r trau | | | Wife | | 1 | | | | | evy Cha | | | | | |
| Je, | of Hee | | 20a. Method of Disposition | ., | | lace of Dispo emetery, crer | sition (Name | e of | | | ary 21, | | ocation - City | | | |
| Ē | Page ment ant: If ury or | | 1 ☐ Burial 2 【③Cremation 4 ☐ Donation 5 ☐ Other (Sp | | ate | tgomery | - | • | | | 008 | Bet | hesda, | Marv1 | and | |
| Balt | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. | | 21. Signature of Funeral Service I | licensee | MO14 | 70 B6 | ethesd | a-Cl | hevv | Chas | ert A. e, Inc. 20814-3 | Pum 7 | phrev l | unera | 1 H | ome/ |
| G. | Physician | 10 V | 23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition | | sed the death h line. 111 Ce1 | n. Do not ent | er the mode | of dyin | g, such as | cardiac o | r respiratory a | rrest, | | Onset | ximate al Betwe and De | ath |
| 4 | /Medical Examiner | | resulting in death) | | as a consequ | | S Caric | | | | | | | 1 M | lont | 11 |
| b | LAMITIME | į. | Sequentially list conditions, if any, leading to immediate | b. Due to for | as a consequ | iongo of): | | | | | | | | | | |
| | uted with a sit and a sit | Examiner | Cause (Disease or injury that initiated events | Due to (or | as a consequ | ience on. | | | | | | | | | | |
| o, | an andrial-tra | | resulting in death) Last | Due to (or | as a consequ | ience of): | | | | | - | | | | | |
| 8760, | cate be executed physician and the burial-transit | dical | 1 | d | | | | | | | | | | | | |
| 9 | death certificate be execut e attending physician and d for use as the burial-trar | Physician/Med | IF FEMALE: | 23c. If yes, outcor | me of pregnar | ncv | | | | | | | | | | |
| Box | death atten | cian | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No | 1 ☐Live birth | n 2 ∐ Fetal t at time of de | death 3□ | Ectopic pre | | | | | | 23d. Date of d Month | elivery Day | Yea | ar |
| P.O. | that the ored | hysi | 9 Unknown | 9□Unknowr | n | | | | | | | | | | | |
| | | | Part II. Other significant condition | ns contributing to death | h but not resu | lting in the un | nderlying cau | ise give | n in Part I. | | 23e. Did to | obacco | use contribute | to the cause | e of dea | ith? |
| oro | requires leen sign hould be | eted | Hypertension | | | | | | | | 1 🔯 🗎 | res 2 | □ No 3□ | Probably | 4 □Unk | known |
| Records, | The law ate has b | Completed by | Hyperlipidemia | | | | | | | | 24a. Was autop | sy | prior to | autopsy find completion | lings ava | ailable se of |
| tal | ificate or, pag | | 25. Was case referred to medical | 1 | | | | | | | 1□ Yes | | death′ 1 ☐ Ye | |) | |
| Ž | Physician: this certific ral director, | To Be | examiner? 1 ☑ Yes 2 ☐ No | Hospital: 1 ☐ Inpa | atient 2∏E | ER/Outpatien | t 3□ DOA | Othe | r- | | <i>(Check only o</i> ne 5 ☐ Resid | | € □Other (Cr | agaiful | | |
| Division or Vital | ding Phystclan: The lav n. After this certificate has funeral director, page 2 | L ii | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending | 28a. Date of Ir | njury Day Year) | 28b. Time of Injury | | . Injury Work | | | 8d. Describe h | | | еспу) | | |
| Sio | Attending r death. ector: After | catic | 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no | ation | | | М | 1 🗆 Y | es 2□N | lo | | | | | | |
| Σį | l or At after d Direc I in by | Certification: | 4 Homicide determin | 20e. Place of I | injury - At hor etc. (Specify | me, farm, stre | eet, factory, | office | | 2 | 8f. Location (S City or Tou | Street ar vn, State | nd Number or i | Rural Route | Numbe | H, |
| _ | spital | | 29a. Certifier 1 🛣 Certifying | Physician: To the be | st of my know | vledge, death | occurred at | the tim | e. date and | d place, a | nd due to the | cause(s | and manner | as stated | | |
| | To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the | Medical | (Check only 2 Medical E | xaminer: On the basis and manner | s of examinati | ion and/or inv | estigation, i | n my op | oinion, deat | h occurre | ed at the time, | date an | d place, and d | ue to the car | use(s) | |
| | To t To t | Σ | 29b. Signature and title of certifier | 1110 | | | 29c. I | icense | number | | | 29d. Da | te signed (Mo | nth, Day, Ye | ar) | |
| | . 1 | | | W HIS | | | | D555 | 559 | | F | ebr | uary 20 | , 200 | 8 | |
| | 10 | | 30. Name and address of person w | | - | | · · | Des | | C+- ' | 216 - 0 | | h = 1 + 3 | m 207 | 70 | |
| | Sta | | Thomas E. Maslen 31. Date filed (Month, Day, Year) | €0 Boeis | atrada Cianat | | | Dr. | rve, | ste. | oro; Gr | een | bert, N | m 207 | / U | |
| | Registr | ar | FEB 2 2 20 | 008 | ALL WARES | A SON | | | | | | | | | | |

DHMH 17 Rev 1/2001

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| | | | 1- State Registrar amend #6,7,88 | ate of Maryland 9 Per ANA BI | l / Bepa Cer | rtment o | of Health 08 JH of Death | and Men | ital Hygi | ene g. No. 200 | 8 05434 |
|---|--|-------------------|--|---|-----------------------|--------------------------------|-----------------------------------|------------------------------------|---------------------------------|-------------------------------------|---|
| P | Physici | an | Decedent's Name (First, Middle, Last) | | | | | | Date of Death | Day Yea | 3. Time of Death |
| | /Medi | cal | HILDA | | VERMIL | | | | 02 | 13 2008 | 3 13:10P ^M |
| | Examir | ner ' | 4a. Facility Name (If not institution, give street MEMORIAL HOSPITAL | and number) | | | vn, or Location | | | 4c. County of De | |
| Fι | uneral | | Social Security Number 6. Sex | 7. Age (In yrs. Ia. | st birthday) | If Under 1 Y | | r 24 Hrs. 8, [| Date of Birth | ALLEGAN 9. B | irthplace (State or Foreign Country) UNK |
| | rector | | 220-10-0368 | 36 88 | Yrs. | Months D | ays Hours | | Month, Day, v 21.1 | 919 (| Country) unk |
| and | > | | Usual Residence of Decedent 10a. State 10b. County | 10c. City | Town or Loc | eation | | | | | 10d. Inside City Limits |
| Maryi | f sho | ţō | MD Allegany | , | mber1a | | | | | | 1 ☐ Yes 2 No |
| n the | r 28a | Director | 10e. Street and Number | | | 10f. Zip Co | de | | 10 | g. Citizen of What (| |
| laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. | ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | a D | 10 N. Liberty Stree | t . | | | 2150 | 2 | | USA | |
| ar dea | tems er mu | Funeral | A | as Decedent Ever in U.S. | . 13. W | Vas Decedent Yes, specify | t of Hispanic Or Cuban, Mexica | rigin? (Specify an, Puerto Rica | Yes or No- | 14. Race - An Black, Wh | nerican Indian, |
| 36 rs affe | ", or i | by F | 1 ☐ Never Married 2 ☐ Married 1 If 3 ☑ Widowed 4 ☐ Divorced Y | Yes 27 No Yes, Give ear or Dates: | | ☐Yes 2🌠 | | | , , , , | Specify: W | |
| 2 hour | atural cal Ex | ed k | 15. Decedent's Education | 10 | 16a. Decede | ent's Usual O | ccupation | | 10 | 6b. Kind of Busines | |
| 215 hin 72 | an "ng Medi | Completed | (Specify only highest grade con | pleted) ollege (1-4or 5+) | (Give k life. D | kind of work d O NOT use re | one during mos etired) | st of working | 1. | ob. Killa of Busines | a/modelly |
| ST sed with year | er th | Con | |) | hou | usewife | 2 | | | own home | |
| Maryland 2 d 2 should be filed th and Mental Hygi | even | Be | 17. Father's Name (First, Middle, Last) | | | | | | | aiden Surname) | |
| ryla hould d Mer | narke | 은 | Roy Bennett | d=1) | 401 11 111 | | | 1 Pear1 | | | |
| Man Ith an | 27 is r r traur | | 19a. Informant's Name/Relationship (Type. P. Kathleen Kaiser/daus | | | | | er or Rural Ro 1 road | | City or Town, State, | |
| re, N s 1 and f Health | If item 27 is marke or other traumatic | | 20a. Method of Disposition | 20b. Pía | ce of Dispos | ition (Name o | of . | Date | | Oc. Location - City of | |
| Pages | nt; if | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remov 4 ☑ Donation 5 ☐ Other (Specify) | al from State | netery, crem | atory or other | rplace) | | İ | | , |
| baltimore, permit. Pages 1 a Department of Hea | Importa any inju once. | 1 | 21. Signature of Funeral Service Licensee Ronal S. Walt | Director | 22. | Name and A | ddress of Facili | ity 1 C | . F. T | n 1.1 | |
| മ ഉപ്പ | 트등등 | | sim 1/1 | Director | | | re MD | |) 55 W. | Baltimore | e Street |
| | | | 23a. Part 1. Enter the disease, or complication shock or heart failure. List only one cau | is that caused the death. | Do not ente | r the mode of | dying, such as | s cardiac or res | piratory arres | st, | Approximate Interval Between |
| | ician | | Immediate Cause (Final disease or condition resulting in death) | JORONARY | ART | ERY | DISG | ASE | | | Onset and Death |
| | dical niner | | | Due to (or as a conseque | | | | | | | γ |
| | | - | Sequentially list conditions, b. — | Due to for all ill nothe quet | rins off: | | | | | | |
| uted | ansit | Examiner | Sequentially list conditions, if any leading to first old cause. Enter Underlying Cause (Disease or injury that initiated events | , | , | | | | | | |
| exec | an an irial-tr | | regulting in death) Leat | Due to (or as a conseque | nce of): | | · | | | | |
| o / oU, ate be executed | physician and the burial-transit | ical | d | | | | | | | | |
| ox ox ox ox ox ox ox ox ox ox ox ox ox o | should be detached for use as a | Physician/Medical | IF FEMALE: | | | | | | | | DPECTE - 1 |
| The law requires that the death certificate has been signed by the attending of | for us | sian, | in the past 12 months? | yes, outcome pf pregnanc □Live birth 2□Fetal d □Pregnant at time of dea | eath 3 🗆 | Ectopic pregn | | | | 23d. Date of do Month | elivery Day Year |
| j å å | y me | nysic | | Junknown | un 5∐¹ | Other (specify | /) | - | | | , |
| s that | deta | | Part II. Other significant conditions contribute | ng to death but not resulti | ng in the und | derlying cause | given in Part I | ı. 2 | 23e. Did toba | cco use contribute | to the cause of death? |
| quires | nid be | ed by | | | | | | | 1 ☐ Yes | 2 X No 3□F | Probably 4 □Unknown |
| D 60 8 | 20 | Completed | | | | | | 2 | 24a. Was an | | utopsy findings available |
| The The | irector, page 2 s | E O | | | | | | | autopsy performe 1□ Yes 2 | ed? prior to death? No 1 □ Ye | completion of cause of s 2 □ No |
| cian: | ector, | Be (| 25. Was case referred to medical examiner? | | | | | of Death (Che | / | | |
| Physi this of | l al | P. | 1 ☐ Yes 2 No Hospita 27. Manner of Death 28a | I Mindatient 2 EH | /Outpatient | 2□ DOA | | | | ce 6 □Other (Sp | ecify) |
| ding Affer | funer | tion | 1 Natural 5 ☐ Pending | a. Date of Injury (Month, Day Year) | Bb. Time of Injury | | njury at Work? 1 □ Yes 2 □ | | Describe how | injury occurred | |
| Atten deat | by the | fica | 3 Suicide 6 Could not be 286 | . Place of injury - At home | e, farm, stree | | | | ocation (Stre | et and Number or F | Bural Route Number, |
| s afte | i p | Certification: | 4 Homicide determined | building, etc. (Specify) | | | | 0 | City or Town, | State) | , and ridge, |
| To the Hospital or Attending Physician: within 24 hours after death. |) (a) (b) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c | | 29a. Certifier 1 Certifying Physician 2 Medical Examiner: C | To the best of my knowle | edge, death | occurred at th | e time, date ar | nd place, and d | lue to the cau | se(s) and manner a | s stated. |
| the h | mplete | Medical | all | nd manner stated. | | | | ain occurred at | | | |
| o ¥i v | 2 8 | | 29b. Signature and title of certifier | | | | ense number | | 29d | I. Date signed (Mor | |
| | | - | | od assume of death (thouse 0) | 3e\ /T = | | 33280 | | | reb 14, | 2508 |
| | | | 30. Name and address of person who complete SUNIL K. GUPTA, M.D. | · | | · . | CDT AND | MD 215 | 0.2 | | |
| | Stat | e | 31. Date filed (Month, Day, Year) | | AVE. | OUPIE | LIKLAND | ED 713 | UZ | | |
| Re | egistra | ar | FEB 2 2 2008 | 32 Registrar's Signatur | 1000 | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** /onth Year Josephine Emily Jacobs February County of Death /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner e.stown tonsville timore 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number If Under 1 Year | If Under 24 Hrs 3. Date of Birth (Month, Day, Year) 3/18/1923 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours 84 Days 1 □ M 2 T F 220-01-1357 Director Usual Residence of Decedent the Maryland 10a, State 10c. City, Town or Location a or 28a-f show be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane, HR238 21228 Pages 1 and 2 should be filed within 72 hours after death winent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural"; or items 23a
Inty or other traumatic event, the Medical Examiner must b US by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White Specify: 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk State Government 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Joseph Stalman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5405 Highview Rd., Halethorpe, MD 21227 Daniel Brown / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐Donation 5 ☐ Other (Specify) 2/20/2008 Crownsville, Maryland Maryland Veterans 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consula nce of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and be executed burial-transi Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months Dav 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 1 K 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Norsing Home 5 Residence 6 Other (Specify) 2 No P 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral (27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.

To the Funeral Director; After 5 ☐ Pending investigation 1 Natural 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar 29b. Signature and title of

31. Date filed (Month, Day,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

2008

FEB22

Registrar's Signature

29c. License number

| | | | 1 - For State Registrar | State of Marylan | | tment of F | | | 200 | 8 05436 |
|----------------------------|--|-------------------------------|---|---|--|---|----------------------------|----------------------|------------------------------------|--|
| | | - | Registrar 1. Decedent's Name (First, Middle, Last) |) | - | incate of | Dealli | 2. Date of De | Reg. No. Z U U | 3. Time of Death |
| 3 | Physici | an | | ncis | Jor | nes | | Febru | Day Yea | ar |
| | /Medic | | 4a. Facility Name (If not institution, give | | | | r Location of Deat | | 4c. County of De | |
| 1 | Examir | er | 7 | ris - Dulane | / | | wson | | Ba | etimore |
| Ä | Funeral | | 5. Social Security Number 6. Sec | x. 7. Age (In yrs. i | last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Bir | th 9. E | Birthplace (State or Foreign |
| | Director | | 212-58-6869 | W 2□F 55 | Yrs. | Months Days | Hours Min. | July 2 | 3,1952 m | Country) |
| | pu , | | Usual Residence of Decedent | I too Cib | y, Town or Loca | tion | | | | dout Inside Office Limite |
| | aryla show dat | = | 10a. State 10b. County | A P | | ma. | | | | 10d. Inside City Limits 1 ☑ Yes 2 ☐ No |
| | he M 8a-f ottfie | 3C | 11/0, 101, | 7 1 | a Ti | more | | | | |
| | with t | Ω̈́ | 10e. Street and Number | ide Drive | | 10f. Zip Code | 1200 | | 10g. Citizen of What | Country? |
| | eath is 23 must | eral | 13.0 | 12. Was Decedent Ever in U. | | | lispanic Origin? (S | | 14 Bace - Ar | merican Indian, |
| 40 | fter d r iten iner | Fun | 1 Never Married 2 Married | Armed Forces? 1 ☐ Yes 2 ☐ No | lf Y | Yes, specify Cub | an, Mexican, Puer | to Rican, etc.) | Black, W | hite, etc. |
| 93 | ursa al',o Exam | by | 3 ☐ Widowed 4 Divorced | If Yes, Give Year or Dates: | 1 | ⊒Yes 2⊡UMo | Specify: | | Specify: | DIACK |
| 21215-0036 | filed within 72 hours after death with the Maryland Hygiene. uther than "natural"; or Items 23a or 28a-f show ent, the Medical Examiner must be notified at | Completed by Funeral Director | 15. Decedent's Edu (Specify only highest grad | cation | | nt's Usual Occup | ation during most of wo | rkina | 16b. Kind of Busines | ss/Industry |
| 2 | thin ise. | nple | Elementary/Secondary (0-12) | College (1-4or 5+) | life. DC | O NOT use retired | d) - | - | FORT | meade |
| | led w lygier ner th | S | 12+1 | 2 45 | γ | nana | ger | /mi | , Maiden Surname) | |
| and | be findal H | To Be | 17. Father's Name (First, Middle, Last) | Time | | | in Mother's Nat | ne (rirst, ivildale, | | |
| Ĕ | nould d Mer narke | ٢ | francis W. 19a. Informant's Name/Relationship (Ty | ma Brinti | 10h Mailing | Addrson (Street | Ma and Number or B | | per, City or Town, State | Zin Cada) |
| Maryland | d2sl than 7 is r traur | | Bach Thomas Valler Helationship (1) | o- Sister | 11 (21) I | 0- 0 - | | 2 | eto, md, | , , , , |
| | 1 an Heal tem 2 | | 20a. Method of Disposition | 20b. P | Place of Disposit | tion (Name of | 1 | Date | 20c. Location - City | |
| <u>o</u> | Pages nent of l | | 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) | temoval from State 1 | T. Z.E | atory or other plac | D-2 | 3-08 | (an colon | Inna Ma A |
| Baltimore, | 그 는 분 등 | | 21. Signature of Funeral Service Licens | | 22.1 | Name and Addre | ss of Facility | 20 5 | A HU DO | Pass |
| B | permi Depa Impo any Ir | | 1 Lough I have | 1 | | and. | Morri | 2 F.H. | Bach. | nd, 21229 |
| ĸ. | | | 23a. il vi11. Enter the disease, or compl anock, o' heart failure. List only of | ications that caused the deatl | | | | | | Approximate Interval Between |
| | Physician | | Immedia e ause (Final disease) condition | HEPATOCELL | | | | | | Onset and Death |
| ij. | /Medical | | resulting in death) | Due to (or as a consequ | | MCEK | | | | |
| | Examiner | | Sequentially list conditions | 0 | | | | | | |
| | p tis | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Unicerying Cause (Disease or injury that initiated events | Due to (or as a consequ | uence of): | | | | | |
| _ | ecution and I-tran | хап | that initiated events resulting in death) Last | c Due to (or as a consequ | uence of): | | | | | |
| 8760, | icate be executed physician and s the burial-transit | | l l | | | | | | | |
| 687 | ficate phys | edical | | 1 | | | | | | |
| Вох | r certi nding use a | N/M | IF FEMALE: 23b. Was decedent pregnant | 23c. If <u>ye</u> s, outcome pf <u>pr</u> egna | | | | | 23d. Date of | delivery |
| ă | that the death certificed by the aftending I detached for use as | Physician/Me | in the past 12 months? 1 ☐ Yes 2 ☐ No | 1□Live birth 2□Feta 4□Pregnant at time of d | | Ectopic pregnancy Other <i>(specify)</i> _ | y | | Month | Day Year |
| Ö | t the by the | hys | 9 □ Unknown | 9∐Unknown | | | | | | |
| S, D | The law requires that the death certifited has been signed by the aftending toge 2 should be detached for use as | by P | Part II. Other significant conditions con | ntributing to death but not resu | ulting in the und | lerlying cause giv | en in Part I. | 23e. Did 1 | tobacco use contribute | e to the cause of death? |
| ord | w require been sign | ed | | | | | | 1 🗆 | Yes 2□No 3□ | Probably 4 Unknown |
| ecc | e law re has be je 2 sho | Completed | | | | | | 24a. Was auto | an 24b. Were | autopsy findings available to completion of cause of |
| <u> </u> | | No. | | | | | | perfo 1∐ Yes | ormed? death | 1? |
| /ita | ysician: The is certificate hadirector, page | Be (| 25. Was case referred to medical examiner? | | | | | ath (Check only o | one) | |
| 7 | Physician: r this certific ral director, | P | 1 ☐ Yes 2X No | | ER/Outpatient | 3□ DOA Oth | 4 LI Nursing F | | | pecify) HOSPCIE |
| D C | ding F | on: | 27. Manner of Death 1 X Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | 28c. Injui Wor | | 28d. Describe | how injury occurred | |
| Sic | Attending r death. ector: After by the fune | cati | 2 Accident investigation 3 Suicide 6 Could not be | 28e. Place of injury - At ho | ome farm stree | - | Yes 2 □ No | 28f Location / | Stroot and Number or | Puml Pouto Number |
| Dívision or Vital Records, | after or A | Certification: | 4 ☐ Homicide determined | building, etc. (Specify | | st, lactory, office | | City or To | Street and Number or wn, State) | nulai noute Number, |
| | Hospital 24 hours a Funeral I | | 29a. Certifier 1 X Certifying Phy. | sician: To the best of my kno | wledge, death o | occurred at the ti | me, date and plac | e, and due to the | cause(s) and manner | as stated. |
| 2 | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral | Medical | (Check only 2 Medical Exami | iner: On the basis of examina and manner stated. | tion and/or inve | estigation, in my o | opinion, death occ | urred at the time, | , date and place, and | due to the cause(s) |
| | To the within 2 To the comple | M | 29b. Signature and title of certifier | | | 29c. Licens | e number | | 29d. Date signed (Mo | |
| | | | | | | Dr | 1372 | - | 2/18/ | 08 |
| | | | 30. Name and address of person who co | ompleted cause of death (Item | 1 23a) (Type, Pr | rint) | | | | |
| | | | DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year) | 2300 DULANE | Y VALLE | Y RD. | TIMONIUM, | MD 210 | 93 | |
| | Sta Registr | | FER 2 2 2008 | Service A service | A STATE OF THE PARTY OF THE PAR | | | | | |

DHMH 17 Rev 1/2001

10:15 р.ш.

FEBRUARY 15, 2008

FRANCIS JONES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Erma Faye Jenkins 9:00am м 19 February 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 10621 Old Court Road Baltimore Woodstock 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 XF Yrs. MD Director 216-32-8187 79 May 1, 1928 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f sh Examlner must be notified MD Baltimore Woodstock 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21163 10621 Old Court Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Whitehead Maggie Smith ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James A. Jenkins (Spouse) 10621 Old Court Rd., Woodstock, MD 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Granite Church Cem. 2/22/2008 Woodstock, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Hard Sykesville, MD 21784 M60764 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Saveneus ecli /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the all the best of the second to be detached to the second to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe page death? 1∐ Yes rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA P 28a. Date of Injury 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation (Month, Day Year) Injury Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB 2 2 2008

nllan

Ken 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

show

within 72 hours after

requires that the death certificate be executed

Box 68760,

P.0.

Division or Vital Records,

Physiclan;

al or Attending F

To the Hospital

and

has

this certificate

After

"natural",

Baltimore, Maryland 21215-0036

29c. License number

011

2908

COURT

29d. Date signed (Month, Day, Year)

-eorvary

For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 19, Robert Henry Joost 2008 February /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)
March 23, 1937 New York 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Hours Min Days 1 X M 2 □ F 70 Vrs 084-30-0522 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic events. 10c. City, Town or Location 10a. State 10b. County Director Maryland Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code #803 20814 United States 4801 Hampden Lane, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Attorney 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Joost Anne Lempert ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4801 Hampden Lane, #803, Bethesda, Maryland 20814 Elaine E. Joost / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) February 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 23, 2008 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service-Licensee M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** neimonia /Medical Due to (or as a consequence of): Examiner disease Y/CINSOM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and & The law requires that the death certificate be executed physician and sthe burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical ast IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal deat
4☐Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Month 5 ☐ Other (specify) ☐Yes 2☐No detached the 9□ Unknown 9 Unknown ģ been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy pertormed 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No P 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation T Natural
2 ☐ Accident Injury 1 ☐ Yes 2 ☐ No death. the Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 38262

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T TA

MENDHIRA

2008

2 FEB

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

10d. Inside City Limits

Approximate Interval Between Onset and Death

o dails

Day

White

1 ☐ Yes 2 No

DHMH 17 Rev 1/2001

5

State

Registrar

2401

Registrar's Signature

Research BLUD Sutto 330

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | For State Registrar | State | of Marylan | | | of Health of Death | | | iene | 2008 | 054 | 39 |
|---------------|---|---------------------|---|----------------------|---|------------------------|----------------------|--|---|--|------------|--------------------------|--|-------------|
| | | | Decedent's Name (First, Middle, | Last) | | | | | | 2. Date of Deat Month | h | Voze | 3. Time of De | ath |
| | Physici /Medic | | Rose Marie Koh | ler. | | | | | | January | 31°, | 2008° | 6:30 P | Мм |
| | Examin | - | 4a. Facility Name (If not institution, g | | ımber) | | | own, or Location 7a1e | of Death | | | ounty of Death legany | 1 | |
| | Funeral | | | . Sex | 7. Age (In yrs. | last birthday) | If Under 1 Months | Year If Under Days Hours | 24 Hrs. Min. | 8. Date of Birth (Month, Day, Jan 3, | Year) | 9. Birth | nplace (State or F | oreign |
| | Director | | 232-36-7642 | 1 □ M 2 💢 F | 81 | Yrs. | Worters | Days | | Jan 3, | 1927 | Wes | t Virgi | nia |
| | and * | | Usual Residence of Decedent 10a. State 10b. County | | 10c, Cit | y, Town or Lo | cation | | | | | | 10d. Inside City I | Limits |
| | Manyli sho | ō | MD Alleg | anv | | LaVal | | | | | | | 1 ☐ Yes 2 | No No |
| | 28a- | rect | 10e. Street and Number | any | | | 10f. Zip C | Code | | 1 | 0g. Citize | n of What Co | untry? | |
| | 3a or | <u> </u> | 12405 Snyder Dr | ive | | | | 21502 | | | | USA | | |
| | within 72 hours after death with the Maryland ene. Then "natural" or Iteme 23e or 28e-f show the Medical Examination in collified at | by Funeral Director | 11. Marital Status | 12. Was Dec | cedent Ever in U. | .S. 13. | Was Decede | nt of Hispanic Or y Cuban, Mexica | rigin? (Spe | cify Yes or No- | 14 | Race - Ame | | |
| 0 | or its | y Fu | 1 Never Married 2 Married | 1 □ Yes If Yes, G | 2 XNo ive | | 1 □ Yes 2 | | | , | s | pecity: wh | | |
| o-0030 | hours tural', | | 3 X Widowed 4 □ Divorced | Year or | Dates: | | dent's Usual | | | | | of Business/ | | |
| <u>γ</u> | in 72 | Completed | 15. Decedent's (Specify only highest | grade completed | | (Give | | done during mos | st of workir | ng | 100. Killu | I OI DUSIII e SSVI | noustry | |
| 7 | y with | om | Elementary/Secondary (0-12) | College 5+ | (1-4or 5+) | | teach | er | | | ρd | ucatio | n | |
| ana | e filec othe vent, | Be C | 17. Father's Name (First, Middle, La | ist) | | | V U U U II | | er's Name | (First, Middle, I | | | .1 | |
| a | Menta Menta arked | 10 | Carl Frederick | Claybo | ur | | | Ma | rie H | lirschle | · | | | |
| al | s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Merial Hygiene. If Health and Merial Hygiene "natural", or Iteme 23e or 28e-f show titem 27 is marked other then "natural", or Iteme 23e or 28e-f show other traumatic event, The Modical Exam the must be couldied at | 1 | 19a. Informant's Name/Relationship | | | | | Street and Numb | | | | Town, State, Z | lip Code) | |
| d) | l and 2 lealth im 27 l | | John T. Kohler/ | son | 20h B | 1240 Place of Dispo | | der Driv | Andrew Control of the Party of | ale, MD | | 502 ation - City or | Town State | |
| E | permit. Pages 1 Department of H Important: If Ite eny injury or ot | | 1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spe | city) | _ | emetery, crer | natory or oth | per place) | | alo | 200. Loca | ation - Oily of | TOWN, State | |
| Dail | permit. Departimont Import eny inj | | 21. Signature of Fineral Struck Lin | Wade | Director | | | Address of Facil natomy I re, MD | | | Balt | imore | Street | |
| | | | 23a. Part 1. Enter the disease, or co shock or heart failure. List or | omplications that | each line. | h. Do not ent | er the mode | of dying, such as | s cardiac o | r respiratory arr | est, | | Approximate Interval Betwe | en |
| | Physician | | Immediate Cause (Final disease or condition | . Are | mary 1 | reler | seni | z Choli | angi | Tis | | | 2 uses | |
| | /Medical Examiner | | resulting in death) | bue to | (or as a conseq | uence of): | - | 3 | 0 | | | | J | |
| | Laummer | 7 | Sequentially list conditions, | b | (or as a conseq | neuce ot). | | | | | | | | |
| | ted nsit | nlne | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | 546 (| (or as a conseq | derice or, | | | | | | | | |
| , | be executed icien and burial-transit | Examiner | that initiated events resulting in death) Last | c | (or as a conseq | uence of): | | | | | | | | |
| 00/2 | w requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit | dical | 8 | d | | | | | | | | | | |
| ŏ | certifical | Medi | IS SSNAIS. | ire i | | | | | | | 1 | | | |
| ŏ | th certendir | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? | 1 ☐ Live | utcome of pregna birth 2 Peta | I death 3 | Ectopic pre | gnancy | | | 23 | d. Date of del Month | very Day Yea | ar |
| | the attented for n | /sici | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4⊟Preg 9⊟Unk | nant at time of d nown | eath 5 | Other (spe | cify) | | | | 10101111 | 24) | |
| Ţ. | The law requires that the see has been signed by the bage 2 should be detached. | | Part II. Other significant condition | s contributing to | death but not res | ulting in the u | nderlying car | use given in Part | ı. | 23e. Did to | bacco use | e contribute to | the cause of dea | ath? |
| g, | signe d be | d by | Ulcerative | | lites | | , , | | | 1 🗆 Y | es 2 🗹 | No 3□Pr | obably 4 Duni | known |
| ecor | w requ | ete | | | | | | | | 24a. Was a | ın | 24b. Were au | topsy findings av | ailable |
| ě | : The law cete has I . page 2 s | Completed | | | | | | | | autop: | med?🗸 📗 | death? | topsy findings av completion of cau | ise of |
| | | 0 | 25. Was case referred to medicat | | | | | 26. Plac | e of Death | 1 ☐ Yes | | T Tes | 2L NO | |
| Ξ. | ding Physician: The h. After this certificete funeral director, pag | To B | examiner? 1 ☐ Yes 2 ☑ No | Hospital: 1 | Inpatient 2 | ER/Outpatier | nt 3 DO | Dther: 4 N | ursing Hor | ne 5 Resid | ence 6 | □Other (Spe | cify) | |
| o L | ng Pth fter th neral | | 27. Manner of Death 1 ☑Natural 5 ☐ Pending | 28a. Date (Mo | of Injury nth, Day Year) | 28b. Time o Injury | f 28 | c. Injury at Work? | 2 | 28d. Describe h | ow injury | occurred | | |
| VISION | ttendii death. tor: A the fu | catle | 2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no | t be | | | М | 1 Yes 2 | | | | | | |
| $\frac{3}{2}$ | or Att | ertification; | 4 Homicide determin | ad 288. Plac | te of Injury - At hidding, etc. (Specif | ome, farm, sti y) | reet, factory, | office | 1 | 28f. Location (S City or Tow | | Number or Ru | ıral Route Numbe | <i>3Γ</i> , |
| _1 | pital ours e erel [| O | 29a. Certifier 1 Certifying | Physician: To the | na hast of my ker | wladne dest | h occurred a | t the time date a | nd place | and due to the a | ause/s) s | ind manner or | stated | - |
| | To the Hospital or Attending Physician: white 24 hours sites deals. To the Funerel Director: After this certification deals in the funeral director. | edical | | caminer: On the | | | | | | | | | | |
| | To the within To the complex | Me | 29b. Signature and title of certifier | | | | 29c. | License number | | 2 | 9d. Date | signed (Mont | h, Day, Year) | |
| | | | > 3 Cha | ngn | 1 | | 1 | 256 | 38 | | Febr | uary | 14,20 | 208 |
| | | | 30. Name and address of person w | no completed car | use of death (Iter | n 23a) (Type, | Print) | 256 Frost | 6. | M. | 1. | , 9, | -37 | |
| | | | SATURALINA C | | Registrar's Sign | W 42 | dwar | 1 Mary | very | lary | and | ₹ (| 5 2 - | |
| | Sta Registr | | 31. Date filed (Month Day, Year) | 2008 | Registrar's Signa | | self) | | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** Hilda Kruth February 15, 2008 2:02PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛛 F August 13, 1923 New York Director 84 112-14-6146 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7 Is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be in 303 Adclare Road 20850 United States death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed by Specify: 3 N Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Homemaker</u> Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Harry Freeman Sarah Leiserin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Feather Rock Drive, Rockville, Maryland 20850 Howard S. Kruth/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fruman
Packard Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Fruman
Ard Cemetery 20, 2008

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia /Medical Due to (or as a consequence of): Examiner Femur Fracture Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Acute Renal Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 K Unknown pege 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Dementia 24a. Was an has autopsy performed?

1 Yes 2 No he certificale Division or Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 1 ☐ Natural 2 【 Accident 5 Pending investigation To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu February 4,2008 9:00AM M 1 Yes 2 No death. Fell from Hover Lift 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town 3 Adclare Road Rockville, Maryland 20850 4 ☐ Homicide Rockville Nursing Home

Registrar DHMH 17 Rev 1/2001

10

State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

STEVEN WILKS, M.D.

FEB 22

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

and manner stated.

5. Wills

22. Registrar's Signature

1 🕅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

8600 OLD GEORGETOWN ROAD, BETHESDA, MARYLAND 20814

00063195

29d. Date signed (Month, Day, Year)

February 15, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- StateAmend #5,9,11-12,15-20c,22,perFH,g877 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vas Alvin **Physician** 9739 0930 M Fred 8008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner #2017 Spring SILVEY monTomery Homecres. If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Numbeaunk 6. Sex 9. Birthplace (State of Foreign **Funeral** Months 1⊠M 2□F Days Hours ntry 579-40-6342 Yrs. Texas Director Dec 8, 1916 Heual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show priner must be notified at 1 ☐ Yes 21 No MD Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14510 Homecrest Road #2017 20906 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filled within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Item eny Injury or other traumatic event, tra Medical Examinations. 1 Yes 2 No unkerty No Jean or Dates: 1936–1946 1 Never Married 2 Married altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk Salesman Auto Sales 17. Father's Name (First, Middle, Last) 111 18. Molher's Name (First, Middle, Maiden Sumame) 8 unk ပ္ Fred Keefe Odell Robinson 19a Informant's Name/Relationship (*Type, Print*) Phyllis Jane Neal/ Executrix Montgomery Co-Police Do 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk 14510 Homecrest Rd. Apt. 2028 Silver String, MD 20906 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State

4 Donation State Chesapeake Crematory 2/25/2008 Beltsville, MD 21. Some of Fueral Service Licensee, ade, Director Name and Adress of Facility Philip D. Rinaldi Funeral Service, PA Silver SPring MD 21201 20910 9241 Columbia Blvd. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ME /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediale cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed inding physician and use as the burlef-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the s should be deteched 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à SELVO 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No 2 No funeral director 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? is or Attending Pater death.

Director; After of in by the funers Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital
within 24 hours a
To the Funerel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

Registrar

State

IRA

31. Date filed (Month, Day, Year)

MODME

1 MD DME

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECHEK

D00428

medical

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Park

2008

Division or Vital Records, P.O. Box 68760,

completely filled in by the Hospital 24 hours a within 2

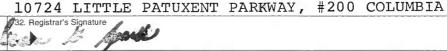
> State Registrar

(

31. Date filed (Month, Day, Year, FEB 2 2 2008

ABDUL

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MUNIM MD

m

29c. License number

D55861

29d. Date signed (Month, Day, Year)

21044

2/13/08

Baltimore, Maryland 21215-0036

| | | 1 - State Registrar | | | | - | artment of I | | | | Reg. No. | 2008 | 05443 |
|--|------------------|---|--|-------------------------------------|--------------------------------|--------------------------------------|---|---|-------------|----------------------------------|-------------------------|---|----------------------------------|
| Physic | | 1. Decedent's Name (Fin | | | | | | | | 2. Date of De Month Februa | Day | Year 2008 | 3. Time of Death 9:49 A |
| /Medi Examir | | 4a. Facility Name (If not | | street and num | nber) | | 4b. City, Town, | | n of Death | CDIGO | 4c. | County of Dear | th |
| Funeral | 8:5 | Stella Ma 5. Social Security Numb | er 6.Se | x | 7. Age (In yrs | s. last birthday) | If Under 1 Year | | er 24 Hrs. | 8. Date of Bir | rth | altimor | hplace (State or Foreign |
| Director | | 213-36-869E | , |]M 2₩F | 68 | Yrs. | Months Days | Hours | Min. | 4/17/1 | 939" | , ,Çc | rginia |
| land ow | | Usual Residence of Dec 10a. State 10b | edent c. County | | 10c. C | City, Town or Lo | cation | | | | | | 10d. Inside City Limits |
| a-fsh | ctor | MD E | Baltimor | е | Bai | ltimore | | | | | | | 1 ⊠Yes 2 □ No |
| vith the | Director | 10e. Street and Number | | | | | 10f. Zip Code | | | | _ | zen of What Co | ountry? |
| ns 23a must | Funeral | 6522 Belle 11. Marital Status | Vista A | 12. Was Dece | dent Ever in | U.S. 13. V | 21206 Was Decedent of | Hispanic C | Origin? (Sp | ecify Yes or No | | JSA 14. Race - Ame | rican Indian, |
| after or iter miner | | 1 ☐ Never Married | 2 Married | Armed For 1 ☐ Yes If Yes, Giv | 2V No | ' | f Yes, specify Cut 1 ☐ Yes 2 | an, Mexic | an, Puerto | Rican, etc.) | | Black, Whit | • |
| hours tural", al Exa | ed by | 3x Widowed 4 □ | Divorced Decedent's Edu | Year or Da | ites: | | dent's Usual Occu | | | | | Specify: What | |
| hin 72 e. an "na Medic | Completed | (Specify o | nly highest grad | e completed) College (1- | -4or 5+) | Give | kind of work done DO NOT use retire | during med) | | ing | 1 | | , |
| led wit lygiend her tha | | Elementary/Secondar | | | | Execu | tive Ass | | | - (First & F. d. H. | | dminist: | rative ——————— |
| should be filed within 72 hours after death with the Maryland and Mental Hygiene. It marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at | To Be | 17. Father's Name (First Hugh Morri | | | | | | 1 | | e (First, Middle t Crawl | | Surname) | |
| shoul and M s mar | ۲ | 19a. Informant's Name/ | Relationship (Ty | pe. Print) | | t and Num | nber or Rur | or Rural Route Number, City or Town, State, Zip Code) | | | | | |
| 1 and 2 Health Im 27 in | | Mark Lange / Son 6522 Belle Vista Ave. Baltimore, Maryla 20a. Method of Disposition (Name of Date 20c. Location - City of Date 20c. | | | | | | | | | | | |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Comp. 20c. Location - City o | | | | | | | | | | | |
| permit. F Departme Importan any injur | | 21. Signature of Funera | | | | <u> </u> | | | | | | | • |
| 8 8 E 8 8 | | Ruck Towson Funeral Home, Inc. 1050 Y | | | | | | | | | | | |
| Dhagisian | | 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition RRFAST CANCED | | | | | | | | | | | |
| Physician /Medical | | disease or condition resulting in death) BREAST CANCER Due to (or as a consequence of): | | | | | | | | | | | |
| Examiner | L | Sequentially list conditions. | | | | | | | | | | | |
| ııted insit i⊀/dd | xamine | Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injury) | diate g | Due to (| or as a conse | equence of): | | | | | | | |
| an and ** | Exa | that initiated events resulting in death) Last | | Due to (| or as a conse | equence of): | | | | 17-1 | | | |
| cate be e | dical | | | d | | | | | | | | | |
| eath certificate be a attending physiciar for use as the buri | Physician/Medica | IF FEMALE: 23b. Was decedent pre- | gnant 2 | 23c. If yes, outo | come pf preg | nancy | | | | | 2 | 3d. Date of del | ivery |
| e death | sicia | in the past 12 mon 1 ☐ Yes 2 💆 No | ths? | | irth 2∏Fe ant at time of | |]Ectopic pregnand]Other <i>(specify)</i> _ | У | | | | Month | Day Year |
| that the de ned by the a detached t | | 9 ☐ Unknown Part II. Other significan | t conditions co | | | sulting in the ur | nderlying cause oi | ven in Par | +1 | 23e Did t | tobacco u | se contribute to | the cause of death? |
| w requires that s been signed b should be det | d by | | | | | | ,g g. | | | | | | obably 4 Unknown |
| ne law red has bee ge 2 shou | Completed | | | | | | | | | 24a. Was | | | utopsy findings available |
| : The cate had page | Com | | | | | | | | | auto perfo 1□ Yes | ormed? 2 X No | death? 1 ☐ Yes | completion of cause of 2 ☐ No |
| ding Physiclan: After this certific funeral director, | o Be | 25. Was case referred to examiner? 1 ☐ Yes 2 No | | Hospital: | npatient 2[| ☐ ER/Outpatien | t 3 DOA Ot | ner | | h (Check only o | | Y | HOCDICE |
| ig Phy ter this neral d | | 27. Manner of Death | D.B. editor | 28a. Date o | <u></u> | 28b. Time of Injury | , oll box | rv at | | me 5 ⊔ Resi 28d. Describe | | | cify) HOSPICE |
| tendir leath. tor: Al the fu | catic | 2 Accident | ☐ Pending investigation ☐ Could not be | | | | M 1 | Yes 2 | | | | | |
| or At fter c jirec n by | Certification: | 4 Homicide | determined | | of injury - At ing, etc. (Spec | | eet, factory, office | | | 28f. Location (City or To | Street and wn, State | d Number or Ru | ural Route Number, |
| - m - m | (C) 1 | II. | | T | | | | | | | | | |
| lospital or At hours after d uneral Direc ely filled in by | | 29a. Certifier | Certifying Phy | sician: To the | best of my kr | nowledge, death | occurred at the t | me, date | and place, | and due to the | cause(s) | and manner as | s stated. |
| To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial completely filted in by the funeral director, page 2 should be detached for use as the bur | Medical (| 29a. Certifier (Check only one) 29b. Signature and tifle | Medical Exami | ner: On the ba | sis of examir | nowledge, death nation and/or inv | occurred at the t vestigation, in my 29c. Licen | opinion, d | leath occur | and due to the red at the time, | date and | and manner as place, and due e signed (Mont | to the cause(s) |

Registrar
DHMH 17 Rev 1/2001

State

2300 DULANEY VALLEY RD.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD

31. Date filed (Month, Day, Year)

FEB 2 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

| | | | State of | Marylar | | artment of H | | Mental Hy | giene | | | |
|------------|---|--------------------|--|---|----------------------------------|---|--|--|-------------------|---------------|------------------------------|------------|
| | | | Registrar | | Cei | rtificate of L | Death | | Reg. No. | 08 | 054 | ا با با |
| 146 | Physici | | 1. Decedent's Nam <i>e (First, Middle, L</i> ast) Frances Bi | ird Lo | ouden | | | 2. Date of De Month Februa | Day | Year 008 | 3. Time of | |
| 4 | /Medic Examir | | 4a. Facility Name (If not institution, give street and num. | | ouden | 4b. City, Town, or | Location of Dea | | 4c. County | | 6:00 | РМ |
| | C LAGIIII | ا ت ا خا | Wilson Healthcare | , | | - | hersbur | | 1 | gome | rv | |
| | Funeral | | 5. Social Security Number 6. Sex 7 | . Age (In yrs. | last birthday) | If Under 1 Year Months Days | If Under 24 Hr Hours Mir | s. 8 Date of Birt | h | 9. Birthp | lace (State o | r Foreign |
| 25. | Director | | 231-18-9710 1□M 2\(\text{\text{\$\tiln\$\$\$}}\$}}\$}}}}}}}}}}}}}}}}}}}}}}}}}}}} | 85 | Yrs. | Worth's Days | Hours Will | May 30 | 1922 | Virg | ginia | |
| | and t | | Usual Residence of Decedent 10a. State 10b. County | 10c. Cit | ty, Town or Lo | cation | | | | 1 | 0d. Inside Cit | ty I imits |
| | Mary -f sho fied a | tor | Maryland Montgomery | | Gaith | ersburg | | | | | 1 X Yes | , |
| | th the or 28a noti | irec | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of W | /hat Cour | ntry? | |
| | 23a cust be | ral | 301 Russell Avenue | | | | 20877 | | Unit | ed S | tates | |
| | er dea tems | Funeral Director | 11. Marital Status 12. Was Deceded Armed Force | es? | .S. 13. \ | Was Decedent of Hi f Yes, specify Cuba | spanic Origin? (n, Mexican, Pue | Specify Yes or No- rto Rican, etc.) | 14. Race Black | - Americ | an Indian, etc. | |
| 36 | rs afte | by F | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give 3 🛣 Widowed 4 ☐ Divorced Year or Dat | | i i | I□Yes 2X No | Specify: | | | Whi | | |
| 21215-0036 | within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show he Medical Examiner must be notified at | ted l | 15. Decedent's Education | | 16a. Deced | lent's Usual Occupa | ation | | 16b. Kind of Bu | siness/Inc | dustry | |
| 215 | thin 7; e. an "n Medi | ple | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4) | 4or 5+) | (Give life. L | kind of work done d OO NOT use retired, | luring most of we) | orking | | | , | |
| 7 | ed wit ygien er th | Completed | 2 | | Assis | tant Dire | | ч | Hospit | | | |
| gu | ould be filed v Mental Hygie larked other t latic event, th | Be | 17. Father's Name (First, Middle, Last) | | | | | me (First, Middle, | | • | d to | |
| Maryland | should and Men marke umatic | မှ | Charles Reuben Bird | | 105.14.75 | | | Ripley | | | | |
| Ma | nd 2 sl tth an 27 is r traur | | 19a. Informant's Name/Relationship (Type. Print) Michael C. Bird / Nephew | | | g Address <i>(Street a</i> E. Sunri d | | | | | | ì |
| ē, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once. | | 20a. Method of Disposition | 20b. F | | sition (Name of natory or other place | - | Date | 20c. Location - 0 | | | 1 |
| altimore, | Pages Tent of I int: If Ite | | 1 X Burial 2 □ Cremation 3 □ Removal from St 4 □ Donation 5 □ Other (Specify) | ale | | morial Park | , = 0.0. | ruary 2008 | Rockvi1 | le. | Marvla | nd |
| a | permit. Departra Importa any Inju | | 21. Signature of Funeral Service Lite age | _ | RO | Name and Addres | _ | | | - | , | |
| <u> </u> | 8 2 2 5 | 1 | Angefette Sun W | M0130 |)5 30t | J West Mont | gomery Av | enue, Rockv | ∕ille, Mar | yland | 20850-2 | 2805 |
| P | | | 23a. Part1. Enter the disease, or complications that caushock, of heart failure. List only one cause on each | used the d <i>e</i> at ch line. | h. Do not ente | er the mode of dying | g, such as cardia | tc or respiratory ar | rest, | | Approximate Interval Bety | veen |
| | Physician / /Medical | | Immediate Cause (Final disease or condition resulting in death) | un | non | ia | | | | 0 | Anset and D | eath |
| | Examiner | | Que to (or | as a conseq | uence of): | Turke | rie to | · lare | | - | | |
| | \$ | ē | Se uentially list conditions b. Due to (or | as a conseq | uence ot): | ia | The state of the s | winn | care as | Ac in | E | |
| | ansit | Examiner | that initiated events | | | | | | V | | | |
| Ö, | e exercian ar | | reculting in death) Leet | as a consequ | uence of): | | | | | | | |
| 98/80 | ficate be executed physician and streets the burial-transit | dical | d | | | | | | | | | |
| | ding p | /Me | IF FEMALE: | omo of progna | no. | | | | | | | V 53 |
| ROX | at the death certific by the attending prached for use as | Physician/Me | in the past 12 hybridis? | th 2 □ F <i>e</i> ta nt at time of d | Ideath 3□ | Ectopic pregnancy Other (specify) | | | 23d. Date Mon | | _ | 'ear |
| j. | the d | nysi | 1 ☐ Yes 2 ☑ No 4 ☐ Fregnar 9 ☐ Unknown 9 ☐ Unknown | | outil o | Other (speedly) | | | | | | |
| ς, J | w requires that the been signed by the should be detache | by PI | Part II. Other significant conditions contributing to dea | th but not resu | ulting in the un | derlying cause give | n in Part I. | 23e. Did to | bacco use contri | bute to th | e cause of de | eath? |
| ecord | equire en sig buld b | edt | Cormanyartery | disc | sel | · crypa | hypard | C- 1□Y | es 2 No | 3 ☐ Prob | ably 4 □U | nknown |
| ပ္ပ | aw s b | Completed | Seizeneditarder. 16 | ldee | ribe | orixer | ilar | 24a. Was a | an 24b. W | /ere auto | osy findings a | ıvailable |
| ř | ate Th | S | occident. Esterp | ALM | sisi | withal | Afracti | perfor | mea:// di | eath? □Yes | | use of |
| VII | Physician: this certific | Be | 25. Was case referred to medical examiner? Hospital: Hospital: | | | | | ath (Check only or | ne) | | | |
| ō | Phy this ald | <u>د</u> | 1 ☐ Yes 2 ☐ No ☐ 1 ☐ Ing 27. Manner of Death 28a. Date of | | ER/Outpatient 28b. Time of | | 4 Let Nursing i | Home 5 ☐ Resid | | |) | |
| 0 | ding h. After fune | tion | | Day Year) | Injury | 28c. Injury Work' M 1 7 Y | es 2 □ No | 280. Describe n | ow injury occurre | ed | | |
| JIVISION | Attendent death ector: | iica Iica | e Could not be | injury - At ho | me, farm, stre | et, factory, office | | | treet and Numbe | r or Rura | Route Numb | oer, |
| 5 | tal or s afte al Dir ed in | Certification: | building | , etc. (Specify | () | | | City or Tow | n, State) | | | |
| | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer | edical | 29a. Certifier (Check only one) 2 Medical Examiner: On the base of means on the page of the control of the co | est of my kno is of examina | wledge, death tion and/or inv | occurred at the time | e, date and plac | e, and due to the o | ause(s) and mar | ner as st | ated. | |
| | thin 2, the land the | Medi | and marine | r stated. | | | | | | | | |
| | 7 W T | | 29b. Signature and title of certifier | 1-1 | | 29c. License | L// | | 29d. Date signed | (Month, I | Jay, Year) | . 5 |
| | | + | 30. Name and address of person who completed cause | of death (Ital) | 23a) (Type 5 | Print) | , 00 | 70811 | 11.00 | my! | o xuc | 10 |
| | 20 | | 14. RUSERTSIRSCH | BALL | + al | 1) 64 | LITHE, | RSBUR | E, MUS | 208 | 17 | |
| | Stat | е | 31. Date filed (Month, Day, Year) 22. Reg | istrar's Signa | ture | 2 p | | | | | | |

DHMH 17 Rev 1/2001

State Registrar Alexander Mulamula, M.D.

2008

31. Date filed (Month, Day, Year)

32. Registrar's Signature

| 08-01284 | |
|------------------|--|
| Leslie McFarland | |

| 8-01284 | | Please Typ | | | | | | | | | gible. | | |
|---|----------------|--|-------------------|--|--------------------|------------------------------|---------------------------------------|--------------------|-------------------------|----------------------------------|----------------|----------------------------|------------------------------|
| eslie McFarlar | | St 1- For State Registrar 1. Decedent's Name (First, Midd) | | ryland | | ment of icate of | Health ar Death | nd Men | | Re | eg. No. | 200 | |
| Physici Iedical Exam | | | | | | | | | l N | Date of Deat Month ebruary | Day | Year | 3. Time of Death 1211 hrs |
| TAL | | Leslie L. McF. 4a. Facility Name (if not institution 7080 Cradlerock Way | | nd number |) | 4 | b. City, Town, o | or Location | | bidary | 4c. C | ounty of Deat | h |
| Funeral | | 5. Social Security Number | 6. Sex | 7. Ag | ge (In yrs. last t | oirthday) | If Under 1 Ye | ar If Unde | er 24Hrs. 8. | Date of Bir | th(MM/DD | | rthplace (State or unk |
| Director | | 470-42-6173 Usual Residence of Decedent | 1XM 2 | F | 85 | Yrs | Months Da | ys Hours | s Min. | June 2 | 29, 1 | 922 Forei | gn uffk ountry) |
| any | | 10a. State 10b. County | | | 10c. City, Tov | wn or Locati | on | <u> </u> | | | | | 10d. Inside City Limits |
| Maryland 28a-f show 1 at once. | J. | MD Howa | ard | | (| Columb | ia | | | | | | 1 Yes 2 X No |
| ith the Maryland 23a or 28a-f she notified at once | Director | 10e. Street and Number 7080 Cradle Ro | ock Way | #912 | - | | 10f. Zip Code | 1045 | | 1 | - | of What Cou USA | untry? |
| MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygien Armen and Trans 23a or 28a-f Sh. 27 is marked other than "natural", or items 23a or 28a-f Sh. matic event, the the dieal Examiner must be notified at once | Funeral I | | larried Arm | ed Forces es 2 | t Ever in U.S. | If Y | s Decedent of H es, specify Cuba | an, Mexican | n, Puerto Rica | | | White, etc. | rican Indian, Black, |
| rs afte rral", | by | 3 Widowed 4 Div 15. Decedent's Education (Spe | vorced If Yes, Gi | | mplotod) 16 | | Yes 2 X N | | | dono 1 | | | hite |
| imore, MD 21215-0036 Pages I and 2 should be filed within 72 hour ment of Health and Neural Hygiene. Inst: If item 27 is marked other than "natt or other traumatic event, the Medical Exal or other traumatic event, the Medical Exal | ompleted | Elementary/Secondary (0-12) | | ege (1-4 or | | during m | t's Usual Occup ost of working lif | e. DO NOT | use retired) | ^{done} unk | TOD. KIN | J OI BUSINESS | unk unk |
| ID 21215-0036 : should be filed within 7 and Mental Hygiene. 77 is marked other than natic event, the M dica | Be Con | 17. Father's Name (First, Middle | | | | | unk | 18.Mother | r's Name (Fin | st, Middle, I | l Maiden Su | rname) | unk |
| 2121 ould be fill I Mental I marked ic event, | To E | 19a. Informant's Name/Relations | ship (Type, Prin | :) | 1 | 19b. Mailing | Address (Stre | eet and Nur | mber or Rural | Route Nur | nber, City | or Town, Stat | e, Zip Code) |
| MD id 2 sho ilth and m 27 is aumatii | | O.C.M.E. | | | Í | | Penn S | | | | | 21201 | |
| nore, ages I and of Heal | | 20a. Method of Disposition 1 Burial 2 Cremation | | | tate cren | e of Dispos natory or oth | ition (Name of c ner place) | emetery, | Da | ite | 20c. Loc | cation - City o | r Town, State |
| Baltimore, MI permit. Pages I and 2.9 Department of Health a Important: If item 27 injury or other traum | | 21. Signature of Funeral Pervice | S. Wade | , biz | ector | | lame and Addre | | | | | | Street |
| Physician | | 23a. Part Lenter the disease, of | complications | hat caused | the death. Do | not enter th | timore ne mode of dying | MD g, such as o | 21201 cardiac or res | piratory arr | est, shock | , or heart | Approximate Interval |
| /Medical =xaminer | | failure. List only one cause Immediate Cause (Final disease or condition resulting in death) | a. Athero: | | Cardiovase | cular Dis | ease | | | | | | Between Onset and Death |
| | | Sequentially list conditions, | b | | | | | | | | | | |
| | mine | if any, leading to immediate cause. Enter Underlying Cause | | r as a cons | equence of): | | | | | | | | |
| executed an and al - transit | Exa | (Disease or injury that initiated events resulting in death) Last | | r as a cons | equence of): | | | | - | | · | | |
| e executed cian and rial - transi | lical | UNPENDED | AMEN | DED | | | | | - | | | | |
| Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be exwinin 24 hours after death. To the Function of After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial. | sician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Uni | he 1 4 1 | ive birth | me of pregnan | 2 Fe | tal death 3 ner (Specify) | Ectopi | ic pregnancy | | | Date of delive onth | ry Day Year |
| that the dended by the | Phy | Part II. Other significant condit | | | th but not resul | ting in the u | inderlying cause | given in Pa | art I. | 23e. Did to | obacco use | e contribute t | o the cause of death? |
| ires that signed I be deta | b | | | | | | | | - 1 | 1 Ye | s 2 N | lo 3 Pro | obably 4 🗸 Unknown |
| of Vital Records, ing Physician: The law requir After this certificate has been sureral director, page 2 should | Completed | | | | | | | | _ 1 | | | prior to death? | completion of cause of |
| Vital Rec ysician: The l his certificate l director, page | Be C | 25. Was case referred to medica | | | | | 26.Pla | ce of Death | (Check only | | | | |
| Vita hysici this o | To B | examiner? 1 ✓ Yes 2 No | Hospital: 1 | Inpatio | ent 2 ER | /Outpatient | 3 DOA | Other ₄ | Nursing Ho | ome 5 | Residenc | e 6 🗸 Oth | er: Scene |
| ing Ph After t | | 27. Manner of Death 1 ✓ Natural 5 ☐ Pen | 1 (| Date of Injudently Date of Injudently Date of Injudently Day, Volume 1 (1) | ury Year) 28 | b. Time of I | · · _ | jury at Worl | _ I | I. Describe | how injury | occurred | |
| Divisior pital or Attend ours after death neral Director: | Certification: | 2 Accident Inve | stigation | Place of In | njury - At home | , farm, stree | et, factory, office | Yes 2 building, e | | Location (| | Number or F | Rural Route Number, City |
| Division To the Hospital or Attend within 24 hours after death To the Funeral Director: | | 4 Homicide 29a. Certifier 1 Certifying P | hysician: To th | | | | red at the time, | | | to the caus | se(s) and r | | |
| To the Hos within 24 h To the Fur completely | Medical | one) 2 ✓ Medical Exa | miner:On the b | | | | | | | | | | |
| H % H 8 | Me | 29b. Signature and title of certified | | 7 | 1 | > 1 | | se number | | | | te signed (M ary 15, 20 | onth, Day, Year) 008 |
| | | 30. Name and address of person | | | • | | <u> </u> | | | | 1 | | |
| | | Zabiullah Ali, M.D. | Assistant M | edical E | xaminer | 111 Pen | n Street, Ba | ltimore, | MD 21201 | | | | |

State 31. Date filed (Month, Day, Year)
Registrar FEB 2 2 2008 DHMH 17 Rev 1/2001 OCME 2006

OCME

| | | | Please Type or Print in Black In State of Maryland / Depa | | - | _ | |
|--------------|--|-------------------------|---|---|--|--|--|
| | | | _ rot | rtificate of Death | Reg. I | 2000 | 05447 |
| Ī | Physicia /Medic | | 1. Decedent's Name (First, Middle, Last) Chester McCray | | 2. Date of Death | Day 3008 | 3. Time of Death 140 9 M |
| b | Examin | | 4a. Facility Name (If not institution, give street and number) | 4b. City, Town, or Location of Death | | 4c. County of Death | |
| | | 4 | PENINSUM REGIONA MEDICA CONTE | SKISBUM | To D . (5) | Hicemi | |
| | Funeral Director | | 5. Social Security Number 216-96-4126 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 45 Yrs. | If Under 1 Year If Under 24 Hrs. Months Days Hours Min. | 8. Date of Birth (Month, Day, Yea June 22, | ···/ | nce (State or Foreign y) |
| | Maryland f show led at | or | 10a. State 10b. County 10c. City, Town or Lo | ocation .vale | | 100 | d. Inside City Limits 1 ☐ Yes 2√ No |
| | r 28a- notifi | Funeral Director | 10e. Street and Number | 10f. Zip Code | 10g. (| Citizen of What Country | |
| | th with | al D | 333 Elzey Ch Road | 21814 | | USA | |
| | ems : | ner | | Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerlo | ecify Yes or No- | 14. Race - American Black, White, etc | |
| 0000 | ours afte ral", or it Examin | by | 1 Never Married 2 Married 1 Yes 2 No | 1 ☐ Yes 2 ☑ No Specify: | | Specify: bla | |
| ייב בייבו | thin 72 ho e. an "natu Medical | Completed | (Specify only highest grade completed) (Give | dent's Usual Occupation kind of work done during most of work DO NOT use retired) | ing unk 16b. | . Kind of Business/Indu | unk unk |
| 7 | led wil lygien her th | Con | unk unk | 1 10 Mothodo Nom | a (Final Middle Marid | / C | |
| ylarıd | is 1 and 2 should be filed within 72 hours after death with the Manyland of Health and Mentel Hygiene. If Health and Mentel Hygiene, and Mentel Hygiene, and T is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at | To Be | 17. Father's Name (First, Middle, Last) | unk 18. Mother's Nam | e (First, Middle, Maid | en Surname) | unk |
| Mar | 12 sh h and 7 is m traum | | | ng Address (Street and Number or Ru | | | |
| บั | 1 and Healt tem 2 | | 20a. Method of Disposition 20b. Place of Dispo | E. Carroll Street | | y MD 2180 | |
| allinor | permit. Pages 1 and 2. Department of Health a Important: If Item 27 is any injury or other trai | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 █ Other (Specify) in state | matory or other place) | | , | |
| ס | permit Depar Impor any in once. | | Renald S. Wade, Director Si | 2. Name and Address of Facility tate Anatomy Board altimore, MD 2120 | 1 655 W. Ba | altimore St | reet |
| | | | 23a. Pant . Enter the disease, of complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. | ter the mode of dying, such as cardiac | or respiratory arrest, |] h | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) a. CRYP TO COCAL (Company) | MENINGITIS | | | Stidet and Death |
| | Examiner | | Due to (or as a consequence of): | , | | | |
| | | Jer | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | • | | | |
| | xecuted and at-transit | xaminer | that initiated events C. | | | | |
| o, | oe execian a | ш | resulting in death) Last Due to (or as a consequence of): | | | | |
| 0 | physic the b | dica | d | | - | | |
| אַכ | certifi nding use as | √/Me | IF FEMALE: 23c. If yes, outcome pf pregnancy | | | 23d. Date of delivery | , |
| o o | The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the buriat-transit | Physician/Medical | in the past 12 months? ILLIVE DIRTI 2 LI retai death 3L | □Ectopic pregnancy □ Other (specify) | | | yay Year |
| ŗ. | s that ned by | by Ph | Part II. Other significant conditions contributing to death but not resulting in the u | nderlying cause given in Part I. | 23e. Did tobacc | o use contribute to the | cause of death? |
| colus, | en sig | ed b | HIV | | 1 ☐ Yes | 2 No 3 Probab | bly 4 Unknown |
| י נ | law re as ber 2 sho | Completed | AIDS | | 24a. Was an autopsy | 24b. Were autops | sy findings available pletion of cause of |
| <u> </u> | : The cate h | Con | | | performed 1□ Yes | ?_ death? | □ M6 |
| N 150 | certific rector, | Be | 25. Was case referred to medical examiner? | Othor | h (Check only one) | | |
| 5 | Phys r this ral dii | <u>2</u> | examiner? 1 Yes 2 No Hospital: Impatient 2 ER/Outpatient 27. Manner of Death 28b. Time of | TO DOA 4 I Nursing H | ome 5 Residence 28d. Describe how in | 6 ☐Other (Specify) | |
| 5 | nding tth. r: Afte e fune | ation | 1☐ Matural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation | Work? M 1 ☐ Yes 2 ☐ No | | , | |
| 227 | or Atte | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, str building, etc. (Specify) | reet, factory, office | 28f. Location (Street City or Town, Sta | and Number or Rural F ate) | Route Number, |
| - | To the hospital or Attending Physician: The law requires that the death certificate be exwitin 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burian | edical Ce | 29a. Certifier (Check only 2 Medical ExamIner: On the basis of examination and/or in | h occurred at the time, date and place exestigation, in my opinion, death occu | and due to the cause | e(s) and manner as stat and place, and due to t | ted. he cause(s) |
| | o the ithin 2 or the or | Med | one) and manner stated. 29b. Signature and title of certifier | 29c. License number | 29d. I | Date signed (Month, Da | ay, Year) |
| | F ≥ F 8 | | perale | 0 63199. | 2 | 14/2008 | , |
| | | | 30. Name and addless of person who completed cause of death (Item 23a) (Type, | | | (' ' | |
| | | | YOGESH VUHRA 614 EASTERN SI | Print) JORE DR., SALISE | WHY, MD | 21804. | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) | all of | ′ ′ | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Nornis 1006 PM lorence February 208 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ba Himone Pardallitown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Director 91 03/31/1916 Maryland 212-42-7564 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 32 Chestnut Hill Lane 21136 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 72 hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify <u>ک</u> Specify: White 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lee Gillingham Marie Baynes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Item 27 i Mr. Lee Norris (Son) 32 Chestnut Hill Lane, Reisterstown, Maryland 21136 Department of Hear Important: If Item of any Injury 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 Durial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery : 02/26/2008 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. Male T-2 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes No
9 Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) o the 9□Unknown s been signed by the should be detach ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably **€** Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 certificate 1□ Yes **2**√N₀ 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital P Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day 28d. Describe how injury occurred After t Injury at Work? Certification: Division or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Funeral Director: itely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

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5401

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edel

FEB 2 2 2008

Dr. Jessa

31. Date filed (Month, Day, Year)

P0066171

old Court Road, Randallstown

February 21 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year rebruar 2008 Ralph Edward Noel /Medical 4a. Facility Name (If not institution, give street and nymber) 4b. City. Town, or Location of Death 4c. Opunty of Death Examiner Sovale dal Canklin **Funeral** Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Director 204-16-1159 81 Feb11,1927 Pennsylvania Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location a or 28a-f show be notified at 10a, State 10b. County 10d. Inside City Limits Director Md. 1 Yes 2 No n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 319 South Newkirk Street 21224 Funeral U.S.A. 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2☐ No Specify. Specify: White ò 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th <u>Truck Driver</u> Shipping If item 27 is marked other or other traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surna Be Walter Noel Bessie Mae Gallager 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Naomi E. Noel (wife) 319 South Newkirk St. Baltimore, Md.21224 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or otl 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4Donation 5Dother (SpecEntombmentCedar Lawn Mem.Pk 2-21-2008Hagerstown, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facili Kaczorowski Funeral Home, P.A Rolw 1201 Dundalk Ave. Baltimore, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** HearT 019 estive /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-transit Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown þ sate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No autopsy perform After this certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 No Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred tural (Month, Day 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director:

21215-0036

land

Baltimore,

Pages 1 and 2 should Mary

Registrar

GEORGE JabaJI 31. Date filed (Month, Day, Year, FEB 2 2 2 State 2

(Check only

29b. Signature and title of certifier

9000 FRANKLIN 32. Registrar's Signature

2248

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

son who completed cause of death (Item 23a) (Type, Print) Sauare

UR Baltimore

21237

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

Certificate of Death

Physician Rosalie Oursler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 7615 Ridge Road Marriottsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 8. Date of Birth Year Sept 30, 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2√ F 214-30-4693 87 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the IM dical Examiner mines have once. 10a, State 10c. City, Town or Location MD Carrol1 Director Marriottsville 10e. Street and Number 10f. Zip Code 7615 Ridge Road 21104 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martin Joseph Antkowiak Rose Ann Czarnecka ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Nancy Oursler (Daughter-in-law) 7615 Ridge Road Marriottsville, MD 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Lake View Mem. Park 4 Donation 5 ☐ Other (Specify) 2/23/2008 21. Signature of Funeral Service Licens 22. Name and Address of Facility
HAIGHT FUNERAL
Sykesville, MD St M00764 23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final ARKINSONS **Physician** Clase disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the buriai-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ک</u> Completed 24a. Was an ate has page 2 s certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 th No Other: 4 \sum Nursing Home P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 1 Natural 5 Pending investigation neral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) allela weepen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 URNUS ATRICK 1000 100 31. Date filed (Month, Day, Year) FEB 2 2 Registrar's Signa State Registrar

Reg. No. 2. Date of Death v 19, February 2008 4c. County of Death Carroll Y^{ear)}1920 9. Birthplace (State or Foreign Country) 10d. Inside City Limits 1 ☐ Yes 2 📉 No 10g. Citizen of What Country? USA Race - American Indian, Black, White, etc. Specify: White 16b. Kind of Business/Industry Department Store 20c. Location - City or Town, State Sykesville, MD HOME & CHAPEL, PA (Box 195) Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

DHMH 17 Rev 1/2001

VINCENT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year February 20, 2008 **Physician** 2:10 A M Milenka Peros /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Croatia 1 □ M 2 K □ F 87 Director 286-48-0370 1920 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10b. County 10d. Inside City Limits 28a-f show notified Director 1 ☐ Yes 2 No Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? s 1 and 2 should be filed within 72 hours after death with if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 7805 Cindy Lane Funeral 20817 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nicola Petros Marija Mars ۵ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sinent of Health an ant: If item 27 Is i Piazza del Colosseo, 00184, Rome, Italy Vera Weill-Halle/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State February Injury or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If a Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22, 2008 Silver Spring, MD 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, MD 20814 21. Signature of Funeral Service Licensee M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 4 ☐ Pregnant at time of death 1 □Yes 2 🖬 No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an has autopsy performed? , page certificate 1∐ Yes Division or Vital Hospital or Attending Physician: 24 hours after death. director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? within 24 hours after deaun. To the Funeral Director: After this of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ۲ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural
2 Accident (Month, Day Year) 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

(Check only one) 29b. Signature and title of certifie

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

22

FEB

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G 31. Date filed (Month, Day, Year) 39. Registrar's Signature

Registrar

Medical

8000/02

Peros, Milenka

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | 1 - State of Maryla State of Maryla | | artment of H rtificate of L | | _ | ene 2008 | 054 | 53 |
|---------------------|---|----------------|--|--------------------------------------|--|--|---|--|---|-------------------------|
| | Physici /Medic | | 1. Decedent's Name (First, Middle, Last) Clarissa l | Palmai | ,, | | 2. Date of Death | 20, 2008 Year | 3. Time of E | Death A ^M |
| | Examin | | 4a. Facility Name (If not institution, give street and number) Victoria House | | 4b. City, Town, or Montgomen | | eath | 4c. County of Death | n | |
| | Funeral Director | | 5. Social Security Number 6. Sex 7. Age (In year 1 → M 2 N F 7 T Security Number 7. Age (In year 1 → M 2 N F 7 T Security Number 7. Age (In year 1 → M 2 N F 7 T Security Number 7 T Security Number 7 T Security Number 7 T Security Number 7 T Security Number 7 T Security Number 7 T Security Number 7 T Security Number 7 T Security Number 7 T Security Number 7 T Security Number 7 T Security Number 8 T Security Number 8 T Security Number 8 T Security Number 8 T Security Number 9 T Secu | rs. last birthday) Yrs. | If Under 1 Year Months Days | If Under 24 H | | O Diel | nplace (State or untry) mania | Foreign |
| | aryland show d at | 'n | Usual Residence of Decedent 10a. State 10b. County 10c. | City, Town or Lo | | T7.11 | · · · · · · · · · · · · · · · · · · · | | 10d. Inside City | |
| | vith the M or 28a-f be notifie | Director | Maryland Montgomery 10e. Street and Number | MIC | 10f. Zip Code | Villag | | . Citizen of What Co | 1 □ Yes untry? | |
| | should be filed within 72 hours after death with the Maryland mind Mental Hyglene. In the Wisher show in marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at | Funeral | 9704 Inaugural Way 11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married | | Was Decedent of Hi If Yes, specify Cuba | 0886 spanic Origin? n, Mexican, Pu | ? (Specify Yes or No- uerto Rican, etc.) | United St 14. Race - Amer Black, White | rican Indian, | |
| 5-0036 | 72 hours a natural", o lical Exam | by | 3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) | 16a. Deced | 1 ☐ Yes 2 🔀 No | Specify: | 16 | Specify: Wh. | nite ndustry | |
| Maryland 21215-0036 | led within 'ygiene. ner than " tt, the Mec | Completed | Elementary/Secondary (0-12) College (1-4or 5+) | 1 | kind of work done of NOT use retired, extile Cui | rator | | Museum | ıs | |
| yland | should be filed v nd Mental Hygie marked other t matic event, th | To Be | 17. Father's Name (First, Middle, Last) Eugene Kovacs | | | Helen | Name (First, Middle, Ma n Neumann | *** | | |
| | es 1 and 2 should to the the and Ment them 27 is marked rother traumatic | | 19a. Informant's Name/Relationship (Type. Print) Ladislau Kovacs/Brother | | Rock Run R | oad, Go | oldvein, Vi | rginia 22 | 720 | |
| Baltimore, | Page ment ant: If ury or | | 1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) | ate of Cemetery | natory or other place Heaven v | | 2008 Si | c. Location - City or Liver Spri | ng, Mary | |
| a D | permit. Departr Imports any inj | | N/ MC | 00198 R | obert A. 557 Wiscor | nsin Ave | ey Funeral e., Bethesd | a, MD 208 | esda-Che ase Inc 14-3501 | c. ' |
| | Physician /Medical | S 15 | 23a. Part1. Enfer the disease, or complications that caused the de shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. | iral a | Leuvis | 502.674 | diac or respiratory arrest | , | Approximate Interval Betw Onset and Do | reen . |
| ji G | Examiner | er | Sequentially list conditions, if any, leading to immediate Due to (or as a consider to find the conditions). Due to (or as a consider to find the conditions). | | | | | | | |
| . | ificate be executed g physician and is the burial-transit | Examiner | Sequentially list conditions, if any, leading to immediate cause. Entite Unidentlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consideration of the constant of the constan | equence of): | | | | | | |
| 08/P0 | rificate be ng physicia as the bu | Medical | d | | | | | | | |
| .O. Box | the death certificate be executed by the attending physician and ached for use as the burial-transit | hysician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown | etal death 3 | Ectopic pregnancy Other (specify) | | | 23d. Date of deli Month | • | ear |
| ecords, r | w requires that the de been signed by the should be detached | by P | Part II. Other significant conditions contributing to death but not re | sulting in the ur | nderlying cause give | n in Part I. | 23e. Did tobad 1 ☐ Yes | cco use contribute to | the cause of de obably 4 □Ur | |
| Hec | @ S C₁ | Completed | | | | | 24a. Was an — autopsy performe 1∐ Yes 2∑ | prior to c | topsy findings a ompletion of cau 2□ No | vailable use of |
| or vital | Physician: this certific ral director, | To Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No | ☐ ER/Outpatient | t 3 DOA Othe | | Death <i>(Check only one)</i> g Home 5 \to Residence | e 6 X IOther (Spec | Group | > |
| 1010 | ending P rath. or; After ti he funera | | 27. Manner of Death 1 X Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | Work | | 28d. Describe how | | Home- | |
| DIVISION | ital or Att us after de ral Direct lled in by t | Certification: | 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At building, etc. (Special Country of the Country of th | cify) | | | City or Town, S | | | er, |
| | To the Hospital or Attending Physician: The I within 24 Hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page. | Medical | 29a. Certifier (Check only) 1 | nowledge, death nation and/or inv | estigation, in my op | oinion, death o | ccurred at the time, date | and place, and due | to the cause(s) | |
|) | wit Co. | | 29%. Signature and little of certifier Melwick | M | 29c. License | 294 | E | Date signed (Month Pebruary 2 | | } |
| | 4 | | 30. Name and address of person who completed cause of death (It John R. Melnick, M.D. 911 Rt | | | aithers | burg, Maryl | and 2087 | 9 | |
| | Sta Registra | | 31. Date filed (Month, Day, Year) FEB 2 2 2003 | nature | E) | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 1720M Margaret Parker 2008 ebruary 17 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hicmica REGIONOL MADICAL SAUSHIM 577.28-1409 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 👿 F 577-28-1409 87 Director Jan 10, 1921 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show 1 ☐ Yes 2√☐ No Director MD Wicomico Salisbury 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò traumatic event, the Medical Examiner must be 1514 Riverside Drive C215 21801 USA or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 5-0036 1 ☐ Yes 2X No Specify. Specify: White Completed by 3 ♥ Widowed 4 Divorced 'natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumer. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) caregiver seniors 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk Be ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Parker/son 35730 Henny Penny Drive Pittsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) neral icelicensee Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pan1. Enter the disclase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ong /Medical Due to (or as a consequence of): Examiner Winselvotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical attending p 33 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 ☐ No. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has certificate 2 25. Was case referred to medical examiner? or Attending Physician; Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the Funeral Director: npletely filled in by the 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only within 24 onel 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) FEB 2 2 3

RODNEY A.

1346 S. DIVISION ST.

SALIGBURY

30. Name and address of person and completed cause of death (Item 23a) (Type, Print)

2008

WENRICH

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** MARY BERNADETTE PAYNE 200 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Genesis Health Care Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🗙 F Director 219-10-7654 83 24, 1924 Maryland Sep. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show Items 23a or 28a-f sh ner must be notified 1 ☐ Yes 2 ☑ No Director Baltimore Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3905 Parkside Drive 21206 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status i "natural", or Items ledical Examiner m Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mertal Hydjene. Important: If item 27 is marked other than "natural", or Item Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examiner any injury or other traumatic event, the Medical Examiner. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2√∑ No Specify: Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Office Worker Grocery Store Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Louis Phillip Kotmair <u>Catherine Agnes Murray</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia H. Payne / Daughter 3905 Parkside Drive, Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp 2-22-08 Towson, Maryland 21. Signatur of Fundal Service McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part1. Enter the disease, or complete shock, or heart failure. List only one of plocations hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed sician and burial-tran Due to (or as a consequence of): ng physician as the burial Box 68760, Physician/Medical IF FFMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant atter for u 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) P.O. I signed by the a d be detached f 1 □ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an has autopsy performe page; certificate 2 No Physiclan: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner' Other: 2 No 2 1 ☐ Yes 1 Inpatient 3□ DDA 2 ☐ ER/Outpatient 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this (28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division or Vital Records, To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu

> State Registrar

ca

31. Date filed (Month, Day, Year)

29b. Signature And title of certifier

(Check only one)



of death (Item 23a) (Type, Print

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 - 05456 Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** February 19, 2008 4:10PM M Lorene Antoinette Quade /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Hospice Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Dave Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birtholace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F Director 84 December 31, 1923 Washington, D.C. 577-34-6342 Usual Residence of Decedent r 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director <u>Maryland</u> Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 20906 death \ Funeral 3203 Ludham Drive United States 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 M Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) ies 1 and 2 should be filed wi of Health and Mental Hygier fitem 27 is marked other th 1 Accountant Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P William Joseph Sullivan Gertrude Halterman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code)
9039 Sligo Creek Parkway #703
Silver Spring, Maryland 20901 19a. Informant's Name/Relationship (Type. Print) Michael Pond/ Nephew permit. Pages 1 ar Department of Hea Important: If item 3 any injury or othe 20b. Place of Disposition (Name of 20a, Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place)
Montgomery 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State February 20, 2008 4 ☐ Donation 5 ☐ Other (Specify) Crematorium Inc. Bethesda, Maryland 22. Name and Address of Facill Robert A. Pumphrey Funeral Home/ Bethesda Chevy Chase Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licenses M00335 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hepatic Encephalopathy disease or condition /Medical resulting in death) Due to (or as a consequence of); Examiner End Stage Liver Disease Sequentially list conditions, if dry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (bries a nonsequence of) Examiner the death certificate be executed and burial-t Due to (or as a consequence of) Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, <u>2</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2K No certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: $_{4}\square$ Nursing Home $_{5}\square$ Residence $_{6}X\!\!\!\square$ Other (Specify) Hospice 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this of funeral direction ٩ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No To the Funeral Director: completely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check on within 24 one) 29c, License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) February 19, 2008 D006415 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 M.D. 6001 Muncaster Mill Road, Rockville, Maryland 20850 Genevieve Wroblewski, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | 1 = For State Registrar | State of Mar | ylan | | | t of H | | and M | | giene Reg. No. | 801 | 05457 |
|----------------|--|----------------|---|--|-----------------|--------------------------------|--------------------------------|------------------------|---------------------------|-------------------------|---|------------------------------|---|---|
| | Physici | an | Decedent's Name (First, Middle, L | ast) Ross | | | | | | | 2. Date of Dea Month | Day | Year Zeo8 | 3. Time of Death |
|) | /Medic Examin | | 4a. Facility Name (If not institution, g | | | | b : | 4 | Location | of Peath | | 4c. Co | unty of Death | |
| | | | Onkland Nur | | - | lo Cent | | ak | lan | . (| | | re He | |
| | Funeral Director | | 5. Social Security Number 6. 214–38–3666 | Sex | in yrs. i 81 | la <i>st birthday)</i> Yrs. | If Under Months | Days | If Under Hours | Min. | 8. Date of Birt (Month, Day Jan 30, | n y, Year) 1927 | | place (State or Foreign ntry) yland |
| | D | | Usual Residence of Decedent | | | /. Town or Lo | l l | | | | | | | 10d. Inside City Limits |
| | Maryle f ehov | ō | MD Garret | | oc. Oily | 0ak1 | | | | | | | | 1 Yes 2 No |
| | r 28e- | Director | 10e. Street and Number | | | | 10f. Zip | Code | | | | 10g. Citizen | of Whal Cou | intry? |
| | 23a o | alD | 706 E. Alder St | reet | | | | | 21550 | | | | USA | |
| | teme | Funeral [| 11. Marital Status | 12. Was Decedeni Eve Armed Forces? | er in U. | S. 13. | Was Deced If Yes, spec | tent of H offy Cuba | ispanic Or In, Mexica | igin? (Spe n, Puerto | ecify Yes or No- Rican, etc.) | - 14. | Race - Ameri Black, White, | |
| 936 | n 72 hours effer deeth with the Marylend "neturel", or Iteme 23a or 28e-f ehow adical Examinar must be rodified at | र्व | 1 ☐ Never Married 2 ☐ Married 3 ☆Widowed 4 ☐ Divorced | 1 ☐ Yes 2 X No If Yes, Give Year or Dates: | | | 1 🗆 Yes | 2⊠ No | Specify | • | | Sp | ecify: W | hite |
| 21215-0036 | 72 ho | Completed | 15. Decedent's (Specify only highest of | Education grade completed) | | 16a. Dece (Give | kind of wo | rk done d | during mos | st of worki | unk unk | 16b. Kind | of Business/Ir | ndustry |
| 121 | | ошо | Elementary/Secondary (0-12) | College (1-4or 5+) 4 | | me. | DO NOT us | e reurec | " | | | eć | lucatio | on |
| | be filed withintal Hygiene. Ind other than event, the M | BeC | 17. Father's Name (First, Middle, La. | st) | | | | | 18. Moth | er's Name | (First, Middle, | | | |
| ylar | should be nd Mental marked c | ToE | Chauncey M. Fri | end Sr | | , | | | | | e Frien | | | |
| Maryland | 12 sho h end h end 7 is m traum | | 19a. Informant's Name/Relationship Howard O. Ross | | | 1 | • | | | | /Route Numbe imore, | | own, State, Zij 1236 | p Code) |
| | Heeith Heeith tem 27 | | 20a. Method of Disposition | 7 5011 | | 」 lace of Dispo | sition (Nan | ne of | | | ate | | ion - City or T | own, State |
| ē | Pages 1 and 2 should ment of Heeith end Men lant: if Item 27 is marke jury or other traumatic | | 1 ☐ Burial 2 ☐ Cremation 3 '4 ☒ Donation 5 ☐ Other (Special | | C | emetery, crei | natory or o | iner piac | (8) | | | | | |
| Baitimore, | permit. Page Depertment of Important: If eny Injury or once. | | 21. Synature of uneral Service Lice Onal S | Wade, Direc | tor | St | Name and attention | Anat | omy E | soard | 655 W. | Balt: | imore : | Street |
| 760, | /Medical Examiner physicien and physicien and physicien and physicien are physician ph | dical Examiner | 23a. Part. Enter the disease or conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | 0 | conseque | uence of): | المراعم | | | | | | | Interval Between Onset and Death |
| P.O. Box 68 | res thet the deeth certifice igned by the ettending ph be deteched for use es th | Physician/Med | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown | 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at tin | Fetal | death 3 | Ectopic pr Other <i>(sp</i> | | | | | 23d. | . Date of deliv Month | rery Day Year |
| | The law requires that the ste hes been signed by the page 2 should be deteched. | Ď | Part II. Other significant conditions | contributing to death but in | | ulting in the u | nderlying c | ause give | en in Part | / | } | | | the cause of death? bably 4 ØUnknown |
| ord | w require been si should b | eted | 100 6 | 1 | | 71 | 11 | 7071 | 12. | 101 | 24a. Was | | | opsy findings available |
| Vital Records, | : The lew cete hes pege 2 s | Completed | CAD Page | la solly | no. | - filma | 1 hy | 400 | 1/5/ | | autop | | prior to co death? 1 \(\sum \text{Yes} | ompletion of cause of |
| /ital | ysician: Th | Bec | 25. Was case referred to medical examiner? | 7 Vec 0 1 | 2) // | / | 10 2 | 2 | | e of Death | (Check only o | ne) | | |
| ð | Phys this ei dir | J. | 1 ☐ Yes 2 Ø No 27. Manner of Death | Hospital: 1 Inpatient 28a. Date of Injury | 2 🗆 1 | ER/Outpatier 28b. Time of | | 8c. Injun | 4 10 14 | | me 5 ☐ Resid 28d. Describe h | | | fy) |
| o | After fune | tion | 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat | (Month, Day Y | ear) | Injury | м | | k? Yes 2□ | No | | | | |
| Division | or Attereder designation | Certification; | 3 Suicide 6 Could not determine | | | | eet, factory | , office | | | 28f. Location (S City or Tox | Street and N vn, State) | umber or Rur | al Route Number, |
| | To the Hospital or Attent within 24 hours effer deets To the Funeral Director: completely filled in by the | edicai C | 29a. Certifier 1 Certifying I (Check only one) 1 Medical Ex | Physician: To the best of raminer: On the basis of earth manner states | caminat | wledge, death ion and/or in | occurred vestigation | at the tin | ne, date a pinion, dea | nd place, ath occurr | and due to the e ed at the time, | cause(s) and date and pla | d manner as a ace, and due t | stated. to the cause(s) |
| | To th To the compl | Me | 29b. Signature and title of certifier | 0111- | | | | | e number | - | | | gned (Month, | |
|) | | | Justandle | 1/1/16 | | | | | 064 | | | | 12/0 | |
| | | | 30. Name and address of person which is chard A. Por | terJ. D.O | , | 311 | W. Y | th 5 | + Su | 7.4 | 1 Oakl | adm | 021 | 550 |
| <u>E</u> | Sta Registr | | 31. Date liled (Month, Day, Year) FEB 2 2 2 | 008 39 Registrar's | Signal | S A | WE ! | | | | | | | |

| embulanz | - | C. Richardson Jr. | | | |
|--|-------------------|--|---------------------------------|------------------------------------|--|
| 8-00919 | | Please Type or Print in Black Indelible Ink. Ensure All Copi | | ible. | o orte |
| JNK UNK | | State of Maryland / Department of Health and Mental F | lygiene | 200 | 8 0545 |
| | | 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) | Reg 2. Date of Death | . No. | 3. Time of Death |
| Physicia edical Exami | | Cumberland C. Richardson Jr | | Day Year | 0850 hrs |
| Ç | | 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deat | | 4c. County of Death | |
| * | | 1600 Blk. W. Lafayette Ave. Baltimore | | | |
| Funeral | \Box | 5. Social Security Number 1 Co. Sec. 17. Age (In yrs. last birthday) If Under 1 Year If Under 24Hi | | Foreig | thplace (State or unk |
| Director | | 214-44-4762 1X M 2 F 62 Yrs. Months Days Hours Mi | n. Aug 2, | 1945 ca | ountry) Maryland |
| any | - | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location | | | 10d. Inside City Limits |
| * | | MD Baltimore | | | 1 X Yes 2 No |
| Maryland 28a-f show d at once. | ᅙ | 10e. Street and Number 10f. Zip Code | 10 | g. Citizen of What Cou | ntry? |
| ith the Maryland 23a or 28a-f sho notified at once. | Director | 1138 Shield Place 21201 | | USA | |
| with ns 23; be no | <u>ra</u> | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (| | 14. Race - Amer White, etc. | ican Indian, Black, |
| r death or iter | Funeral | 1 Never Married 2 Married Armed Forces? unker If Yes, specify Cuban, Mexican, Puerl | to Ricall, etc.) | | |
| s after rral", | <u>a</u> | 3 X Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind or | fuunk dana a ma 1-1 | | lack |
| 2 hours a: "natural | ţe | 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) | etired) | TOD. Killa of Basilless | unit |
| 036 ithin 72 ne. r than ' | Completed | unk 9 unk Butcher | | Grocery Sto | ore |
| 5-0036 iled within 7 Hygiene. I other than | S | | ne (First, Middle, M | | unk |
| 121 I be fil ental I arked vent, | Be | Cumberland C. Richardson, Sr. Lillian I | Hall | | |
| Ore, MD 21215-0036 set I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f shother traumatic event, the Medical Examiner must be notified at once | ٩(| 19a. Informant's Name/Relationship (Type, Print) (Sister) 415 Watty Ct. (Signal and Number of Partitione, 1 | MD 21201 Numi | per, City or Town, State | e, Zip Code) |
| - p # e # | ŀ | O.C.M.E. Ms. Elaine Richardson 111 Penn Street Bal 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, | Date Date | 20c. Location - City o | Town, State |
| more, N Pages I and ent of Health nnt: If item | | 1 XBurial 2 Cremation 3 Removal from State crematory or other place) | - (| | |
| Baltimore, permit. Pages I ar Department of Hee Important: If ite | ŀ | | 5/2008 | Lansdowne. | W - North Ave |
| Balti permit. Departm Imports | ŀ | 21. Signature of Funeral Service Licensee Ronald S. Wade, Director Baltimore, MD 2 | 1201 2121 | . Bartimor | e"Street". |
| Physician | | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line. | | | Approximate Interval Between Onset and |
| /Medical | | Immediate Cause (Final disease a. Gunshot wound of chest | | | Death |
| tammer | | or condition resulting in death) Due to (or as a consequence of): | | | |
| | ē | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of): | | - | |
| | amine | cause. Enter Underlying Cause (Disease or injury that initiated | | | |
| ted Insit | Exa | events resulting in death) Last Due to (or as a consequence of): | | | |
| 760, icate be execute physician and the burial - tran | ical | UNPENDED | TII -076 2 | /20 /00 mm | |
| 60, ate be hysici e buri | Physician/Medical | UNPENDED #5,51,12,15,16a-b,17,18,19a-b,20a-c,22,per | rrn,go/0, 2 | / 29/ 00 11 23d. Date of delive | Ty |
| Box 68760, e death certificate be the attending physic ed for use as the bur | jan/l | 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic preg | nancy | Month | Day Year |
| ox 6 eath cer eattendi | /sic | 1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify) g Unknown | | | |
| that the d | | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. | 23e. Did to | bacco use contribute to | the cause of death? |
| P.C. | d by | | 1 Yes | 2 🗸 No 3 Pro | bably 4 Unknown |
| ords, w requires been s been should | Completed | | 24a. Was a | | utopsy findings available completion of cause of |
| eco ne law te has ge 2 sl | dmc | | perform | med? death? | |
| tal Rection: The certificate ector, page | ပိ | 25. Was case referred to medical 26.Place of Death (Chec | | | |
| of Vital Records, P.O. ng Physician: The law requires that th After this certificate has been signed by noral director, page 2 should be detach | To B | examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Number 1 | sing Home 5 | Residence 6 🗸 Othe | er: Scene |
| 1 of Ving Phy. After the funeral | | 27. Manner of Death 28a. Date of Injury 1 Natural 5 Reading Feb 2, 2008 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work? 0000 hrs 1 Yes 2 V No. | 28d. Describe h Subject shot | ow injury occurred | |
| Division ra for Attendii ra Director: A | Certification: | 2 Accident Investigation | | | |
| JVISI I or At after d I Direct | ijij | 3 Suicide 6 Could not be determined (Specify) Local Street | or Town, St | tate) | tural Route Number, City |
| Spi file | | 29a. Certifier | | Lafayette Ave., Balt | |
| To the Howithin 24 is To the Funcompletely | Medical | (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred | d at the time, date a | and place, and due to t | he cause(s) |
| To To Com | Mec | and manner stated. 29b. Signature and title of certifier 29c. License number | | 29d. Date signed (M | |
| | | in his not | | February 3, 200 | 8 |
| (h) | } | 30. Name and address of person who completed cause of death (Item 23a) | | | |
| (0) | | Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 | | | |

State Registrar

DHMH 17 Rev 1/2001
OCME 2006

State Registrar

31. Date filed (Manth Bay Year) 2008

00ME

ORIGINAL

00 ME

37 /Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** DANIEL JOSEPH REARDON JR. 20. 2008 8:50 A FEBRUARY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2 □ F 224-44-1075 July 11, 1936 Virginia Director Usual Residence of Decedent after death with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County "natural", or Items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 502 Lloyd Place Unit A 21014 USA 14 Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. ò 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) marked other than 12 Supervisor Railroad Counting Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) jes 1 and 2 should be to of Health and Mental I Daniel Joseph Reardon Sr. Marquerite Lynch White ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S 502 Lloyd Place Unit A, Bel Air, Maryland 21014 of Disposition (Name of Date 20c. Location - City or Town, State Sandra J. Reardon / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 Injury or 1 Burial 2 Cremation 3 Removal from State Department of Important: If any Injury or once. Mt. Pleasant Cem. Eliot, Maine 4 □ Donation 5 □ Other (Specify) unk 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. (uss 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final disease or condition resulting in death) Two How **Physician** ocavdia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence burial-tra Due to (or as a consequence of) Physician/Medical the as 1 ed by the attending | detached for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ئم cate has been signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 □ Rrobably 4 □ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division or 27. Manner of De th 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 24 hours after death. 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 [Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie è

State

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

441ckay Mence

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Robert Sterrett 2008 15, Feb. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Greater Baltimore Medical Center Towson 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 213-36-7704 69 Director 2, 1938 Maryland July Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 28a-f show 1 ☐ Yes 2 No 7 is marked other than "natural", or Items 23a or 28a-f sh traumatic event, the Medical Examiner must be notified Lutherville Baltimore Funeral Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 USA 1441 Bellona Avenue 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. be filed within 72 hours after ontal Hygiene. A other than "natural", or Iter y Yes 2□No Viet MYes, Give Year or DatesNam Era 1 ☐ Never Married 2 ☑ Married Black 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify ρ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) William Allbright Elementary/Secondary (0-12) College (1-4or 5+) 10th grade <u> Horse Trainer</u> Farms 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental Marie Sterrett ပ္ Robert P. Hayman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1093 19a. Informant's Name/Relationship (Type. Print) 1441 Bellona Avenue Lutherville, Maryland Carmelita Sterrett/Wife of Health a item 27 ls other t 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of He
Important: If iten
any Injury or oth
once, Dulaney Valley Memoria 10 Gar Timonium, Maryland 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 21. Signature of Funeral Service Licensee complications that caused the death. Do not enter the mode of dying, such as-cardiac or respiratory arrest, art1. Ente the disease shock, o neart failure. e, of complications that causes ... List only one cause on each line. Lancinonia Immedia Cause (Final ase or condition resulting in death) Seven monto **Physician** /Medical Due to (or as a const uence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): physician the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an rector, page 2 s perform 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Medical Certification: To Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA No Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760. Division or Vital Records, Hospital or Attending Physician: within 24 hours aft

To the Funeral D

completely filled in

I Director: /

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signates and title of certifier

State

Registrar

Manshall A. 31. Date filed (Month, Day, Year)

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LEUIHR



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** B. Sonneborn 2008 Mildred /Medical Facility Name (If not institution, give street and number 4b. City Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs Social Security Number Birthplace (State or Foreign Country) **Funeral** Year) Days Months 1 □ M 2 M F Hours 1/23/1918 212-01-2060 Director 90 Marvland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ns 23a or 28a-f shov must be notified at MD Baltimore Parkville Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 8832 Walther Blvd. 21234 items 23a USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: $\mathcal{D} \cap \mathcal{C}(\mathcal{O}(\mathcal{O}) \setminus \mathcal{O}(\mathcal{O})$ Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 ☐ No Specify: White 3 ₩ Widowed 4 Divorced er than "natur", the Medical F 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ges 1 and 2 should be filed within t of Health and Mental Hygiene. If Item 27 is marked as Elementary/Secondary (0-12) College (1-4or 5+) Secretary Legal 12 Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Not Known Myrtle (unknown) ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2002 Clipper Park Road Suite # 108 Baltimore, MD Charles S. Winner / Attornev 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-22-08 Hilltop Serv. Corp. 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Emphseme

Due to (or as a consequence of): **Physician** disease or condition resulting in death) oyear /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed the burial-transi and Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ed by the a 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by certificate has been si rector, page 2 should l 1 ☐ Yes 2 ☐ No 3 Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 25 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 EANatural 2 □ Accident 5 Pending investigation ai or Attendi s after death. ii Director: A death. 1 Yes 2 No filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral C rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

10

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

pussell

WILLIAM

31. Date filed (Month, Day, Year)

F death (Item 23a) (Type, Print)
8300 Walte Blod Boltmore MD 21234

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** SONEN 11:42 P M MILO FEB 19 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4201 Linthicum Road Dayton Howard 8. Date of Birth
June 22, 1914 If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign DC. **Funeral** Months 1 ₹ M 2 □ F 577-16- 9735 93 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 28a-f show notified at 1√ Yes 2 No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be re must be 3500 Forest Edge Dr. Apt. 3G 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2**X** No Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Educator Education permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 is marked othe any Injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bright Robert Sonen Blanche Helen Wilcox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type. Print) Mrs. Virginia Sonen (Spouse) 3500 Forest Edge Dr., Apt. 3G Silver Spring, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation | 2/22/2008 4 Donation 5 Other (Specify) Sykesville, MD 21. Signature of Funeral Service License 22 Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Sykesville, MD 21784 Nas 400764 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician RESPIRATURY weeh /Medical Due to (or as a consequence of Examiner PARKINSON GEA11 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ATHERISCLEROAL CARDIOVASCUCAR Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performe 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Hother (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation death. 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D51260 20, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2044 DAIVE TONATHON PIJH 10700 CHARTER 4700 COLUMBIA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend taiten Mary And Department of Please of Death

Certificate of Death

Reg. No. 2

| | | | 1 - State Registrar | — INARYIAN | | tificate of | | | Reg. No. | 2008 | 05464 |
|---------------------|---|----------------|--|---|------------------------------------|---|--|--|--|----------------------------------|--|
| | Physici | » an | 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month | | | | | | ath Day | Year | 3. Time of Death |
| | /Medic | al | Jerald R. Stras | 4b. City, Town, or Location of Death | | | | 2008 | 11:00 AM | | |
| | Examin | er | 4a. Facility Name (If not institution, give street ar Suburban Hospital | na number) | | | _ | | 1 - | County of Death | 10 |
| - | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. I | ast birthday) | Bethesda If Under 1 Year If Under 24 Hrs. 8. Date of B | | | Birth Day, Year) 9. Birthplace (State or Foreign Country) | | |
| 25 | Director | | 095−34−6644 1X M 2□ | B0 | Yrs. | Months Days | Hours Min. | (Month, Day April 2 | 7, 19 | 27 Czec | ch Republic |
| | yland how at | | 10a. State 10b. County | 10c. City | , Town or Lo | cation | | | | 1 | 0d. Inside City Limits |
| | e Ma 3a-f s tiffied | Director | Maryland Montgomery | Ro | ckvi1 | Le | | | | | 1 ☐ Yes 21X No |
| | or 24 | Dire | 10e. Street and Number | 1119 | | 10f. Zip Code | | i | | en of What Cour | , |
| | s 239 nust | eral | 10401 Grosvenor Place | | C 140.1 | 20852 | lan la O d-la 0 (O | | | ed State | |
| 39 | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notifiled at | by Funeral | 1 Never Married 2 Married 1 If Ye | Decedent Ever in U.; ed Forces? Yes 2⊠No es, Give r or Dates: | l' | Vas Decedent of H f Yes, specify Cuba □ Yes 21 No | Specify: | oecity Yes of No- o Rican, etc.) | i | Black, White, Specify: Whi | etc. |
| 2 | 72 hou | eted | 15. Decedent's Education (Specify only highest grade comple | eted) | 16a. Deced | ent's Usual Occup | ation during most of work | kina | 16b. Kin | d of Business/Ind | dustry |
| Maryland 21215-0036 | within ene. than " | Be Completed | Elementary/Secondary (0-12) Colle | ege (1-4or 5+) | | kind of work done of NOT use retired | | I | | Lav | N. |
| 9 | filed Hygi other ent, t | | 17. Father's Name (First, Middle, Last) | | | | 18. Mother's Nam | | Maiden S | | • |
| /lan | should be and Mental marked o | To B | Jaroslav Straslicka | | | | Stepank | a Sypec | ka | | |
| lan | 2 sho and is ma rauma | | 19a. Informant's Name/Relationship (Type. Print | • | | g Address (Street | | | | • | • |
| | 1 and 2 Health em 27 | | Marcela B. Stras / Da 20a. Method of Disposition | | | Haddingto | on Place, | Bethes | | Iaryland | |
| Baltimore, | S = 0 | | 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal | from State | emetery, cren | natory or other plac | 1 | uary 21, | | esda, Ma | |
| Ħ | permit. Page Department of Important: If any injury or once. | 1 | 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee | Pont | 22 | Crematorium . Name and Addres | ss of Facility Ro | ert A. | Pump1 | rey Fun | eral Nome/ |
| <u>~</u> | lang Pen | a G | > the M 1/2 | MO14 | 73 Be | thesda-Cl thesda, N | nevy Chas Maryland | e, Inc. 20814-3 | , 755 501 | 7 Wisco | nsin Ave. |
| | 2 | | 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause | that caused the death on each line. | . Do not ente | er the mode of dyin | g, such as cardiac | or respiratory an | rest, | | Approximate Interval Between Onset and Death |
| | Physician /Medical | | Immediate Cause (Final disease or condition resulting in death) | Pulmonary | | us | | | | | Oliset and Death |
| | Examiner | | Du | ue to (or as a consequ | ience of): | - | | | | | |
| | | ner | Sequentially list conditions, if any, leading to immediate | ue to (or as a consequ | ience of): | | | | | | |
| 17 | ecuted ind transit | Examiner | Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | |
| 68760, | rificate be executed g physician and as the burial-transit | | Due to (or as a consequence of): | | | | | | | | |
| 687 | tificate ig phys as the | edical | d | | | | | | | | |
| Вох | | - | | s, outcome pf pregna Live birth 2 ☐ Fetal | | F-4 | | | 23 | 3d. Date of delive | ery |
| O. B | 0 0 0 | sician/N | 1 DVes 2 DNo 4 DI | Pregnant at time of de Unknown | | Ectopic pregnancy Other (specify) | | | | Month | Day Year |
| Д. | that the | Phy | Part II. Other significant conditions contributing | to death but not resu | Iting in the un | derlying cause give | en in Part I. | 23e. Did to | bacco us | e contribute to the | ne cause of death? |
| Records, | The law requires that the te has been signed by the sage 2 should be detache | ed by | | | | | | 1 🗆 Y | ∕es 2 K | No 3□ Prob | ably 4 Unknown |
| ပ္ပ | law re as bee 2 sho | Completed | | | | | | 24a. Was a | | 24b. Were auto | psy findings available mpletion of cause of |
| ř | 60 17 | Som | | | | | | autop perfor 1⊟ Yes | rmed? | death? 1 ☐ Yes | |
| Vital | ilng Physiclan I. After this certifi funeral director | Be (| 25. Was case referred to medical examiner? | | | Tou | 26. Place of Dea | th (Check only or | пе) | | |
| | | P | 1 ☐ Yes 2 ☒ No Hospital: 27. Manner of Death 28a. | 1 ☑ Inpatient 2 ☐ I | ER/Outpatient 28b. Time of | | 4 LI Nursing H | ome 5 Resid | | | y) |
| o O | | tion | 1X Natural 5 Pending 2 Accident investigation | Injury | 28c. Injury at Work? M 1 Yes 2 No | | 28d. Describe how injury occurred | | | | |
| Division or | Atter er deal ector by the | Certification: | 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 28e. Place of injury - At home, farm, street, factory building, etc. (Specify) | | | | , factory, office 28f. Location | | n (Street and Number or Rural Route Number, | | |
| <u>ה</u> | Hospital or Attending Public Application Puneral Director: After the filled in by the fune | Cert | | | | | | City or Tow | | | |
| | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the | Medical | 29a. Certifier (Check only one) 1 \(\mathbb{Z}\) Certifying Physician; T (2 \(\mathbb{M}\) Medical Examiner: On and | o the best of my know the basis of examinat manner stated. | vledge, death ion and/or inv | occurred at the ting restigation, in my o | ne, date and place pinion, death occu | , and due to the or rred at the time, | cause(s) a date and p | and manner as solace, and due to | tated. the cause(s) |
| | To the within 2 | Me | 29b. Signature and title of certifier | 1 | | 29c. License | e number | 2 | 29d. Date | signed (Month, | Day, Year) |
| | | | 1 James | lock | M.] | D5561 | 12 | | February 20, 2008 | | |
| | ,6 | | 30. Name and address of person who completed | | , , | · | | | | | |
| | , | | James Morton, M.D. 860 | 00 01d Geo: | ure 4 | | Bethesda, | Maryla | nd 20 | 0814 | |
| | Sta | le | TED 9 9 2008 | 32. Registrar's Signat | ure | 20 | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | 1 December Name /First Middle Local | Otate of Mary | Cei | tificate of | Death | _ | eg. No. | JO U | 2463 | |
|---------------------|--|------------------|--|--|--|---|---|-------------------------------------|------------------|-----------------------------------|---|--|
| Physic | | an | 1. Decedent's Name (First, Middle, Last | | RAGINS | | | 2. Date of Deat Month | Day | 14 | Time of Death | |
| 1 | /Medic Examir | | 4a. Facility Name (If not institution, give | | -11-11-12 | | 4b. City, Town, or | FCMVMy Location of Death | 4c. County | | 10-10 | |
| | Lxamii | IGI | CHESTNUT GREEN | | 121 | | TOWSUN | | BAR | 2 more | - | |
| | Funeral | Г | Social Security Number 6. Se | 7 t | n yrs. last birthday) | If Under 1 Year Months Days | If Under 24 Hrs Hours Min. | 8. Date of Birth (Month, Day, | Year) | 9. Birthplace | (State or Foreign | |
| | Director | | 212-18-3662 | 2 ZAJF 8 | 88 Yrs. | | 1100.0 | Aug. 9, | 1919 | Maryla | | |
| 020 | land | | Usual Residence of Decedent 10a. State 10b. County | 10c. City, Town or Location | | | | | | | nside City Limits | |
| | Mary a-f sh | Funeral Director | Maryland Baltimore Towson | | | | | | | | | |
| | th the | | 10e. Street and Number | | | 10f. Zip Code | | 1 | 0g. Citizen of W | hat Country? | | |
| | ath wi | la | 1055 W. Joppa Roa | ad | | | 21204 | | U. | S.A. | | |
| | er de | nue | | 12. Was Decedent Ever Armed Forces? | r in U,S. 13. V | Vas Decedent of H Yes, specify Cub | lispanic Origin? (S an, Mexicen, Puert | pecify Yes or No- o Rican, etc.) | | e - American Ir k, White, etc. | ndian, | |
| | irs aft | by F | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 Year or Dates: | | ☐ Yes 2☐XNo | es 2 No Specify: | | | Specify: White | | |
| Maryland 21215-0020 | be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23a or 28a-f show event, the Madical Examinating the mailined at | To Be Completed | 15. Decedent's Edu | cation | 16a. Deced | ent's Usual Occur | pation | 1.i | 16b. Kind of Bu | | y | |
| 21 | ithin 7 | | (Specify only highest grad Elementary/Secondary (0-12) | life. L | (Give kind of work done during most of working life. DO NOT use retired) | | | | | | | |
| 2 | ld be filed with ental Hygiene kad other that ic event, the | | 17 Entharia Nama (First Adiddle 1 ant) | 2 years | Hon | nemaker | 40 14-41 - 4-14- | (5:-4 84:415- 8 | Own H | | | |
| and | d be fi | | James Henry O'Cor | 1 1 | | | | ne (First, Middle, M | | Β) | | |
| <u></u> | 2 should and Men is marka | | 19a. Informant's Name/Relationship (Ty | | 19b. Mailin | a Address (Street | | t Lee] ra Route Number | Hodges | State. Zip Cod | (e.) | |
| | and 2 salth a n 27 is er trau | | Samuel H. Spragins | | | | | Drive We | - | | | |
| gaitimore, | es 1 a of Her | | 20a. Method of Disposition | 2 | Ob. Place of Dispos cemetery, crem | sition (Name of atory or other place | ce) | | 20c. Location - | | | |
| Ĕ | Pages ment of l ant: If its ury or o | | 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cemetery, crematory or other place) Dulancy Valley Memorial Cardens 2-23-18 Timonium, Maryland | | | | | | | | | |
| da L | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28af show any injury or other traumatic event, the Medical Examination invest be indiffed at once. | | 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 | | | | | | | | | |
| | 00 = 0 O | | Deorge Le | vare | | | | | | | 1212 | |
| | 8 | | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or | cations that caused the ne cause on each line. | death. Do not ente | er the mode of dyir | ng, such as cardiad | or respiratory arre | est, | App Inte | roximate rvel Between set and Death | |
| | Physician /Medical | | Immediate Cause (Final | | | | | | | | | |
| | Examiner | | Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or es a consequence of): Due to (or es a consequence of): Due to (or es a consequence of): Due to (or es a consequence of): Due to (or es a consequence of): Due to (or es a consequence of): The farty, leading to immediate cause. Enter Underlying Drobable me to both connect where of the connect | | | | | | | | | |
| | D # | Examiner | | Achal | <51'9 | 30.130 0.7. | | | | m | ntus | |
| | æcute and I-trans | | Sequentially list conditions, Due to (or es a consequence of): | | | | | | | | 10 | |
| Š, | be ey iician buria | ם | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | | | | | | | an | why | |
| 08/PN | certificate be executed Iding physician and Lse as the burial-transit | edical | that initiated events resulting in death) Last Due to (or as a consequence of): | | | | | | | | | |
| X Q | es ig | by Physician/M | | l | | | | | | | | |
| | e death | | Part II. Other significant conditions con | tributing to death but no | ot resulting in the un | derl y ing cause giv | en in Part I. | 23b. Did to | bacco use con | tribute to the | cause of death? | |
| т. Э | The law requires that the death ate has been signed by the atter page 2 should be detached for u | | Chriz obihverre polinovery defease 10 Yes 20 No 30 Pr | | | | | | | | 4 ☐ Unknown | |
| as, | signe d be | d by | 24a. Was an autopsy 24b. Were a | | | | | | | | utopsy findings | |
| ecoras, | v requ been shoul | iete | | | | | | perform | red? | availabl complet | e prior to tion of cause | |
| Ď | The law ate has page 2 | Completed | | | | | | 10.0% | a pullena | of death | The second second | |
| N I G | ician: The certificate rector, pag | Be | 25. Was case referred to medical | | | | 26 Place of Dea | 1 L Ye th (Check only one | / | 1 LI Yes | s 2∐ No | |
| <u> </u> | ysicia is cer direc | TO B | examiner? 1 ☐ Yes 2 ☑ No | ospital: 1 🗌 Inpatient | 2 ER/Outpatient | 3□ DOA Oth | | ome 5 Reside | | r (Specify) | | |
| o = | ng Ph fter th meral | | 27. Manner of Death 1. SNatural 5 □ Pending | 28a. Date of Injury (Month, Day Yea | 28b. Time of Injury | 28c. Injur Wor | | 28d. Describe ho | | | | |
| 200 | tendii Jeath. tor: A the fu | cati | 2 Accident investigation 3 Suicide 6 Could not be | | 1 ☐ Yes 2 ☐ No | | | | | | | |
| DIVISION OF | or At after d Direc | ertification: | 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Foundation) City or Town, State) | | | | | | | r or Hurai Hou | ite Number, | |
| _ | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifici completely filled in by the funeral director, | edical C | 29a. Certifier (Check only one) Check only one) | | | | | | | | | |
| | o the | Mec | 20h Signature and title of cortifier . | and manner stated. | | 29c. License | e number | 29 | d. Date signed | (Month, Day, | Year) | |
| | r s r ő | | Mearl | mpleted cause of death | | D | 5830 | 3 8 | esno | vry 2i | 2003 | |
| | ĺ | | 30. Name and address of person who con | mpleted cause of death | (Item 23a) (Type, F | Charles | St To | Moser | no 2/2 | zas | | |

32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician 06:15 PM ANNA AMELIA SOTH STAMBAUGH 2008 FEBRUARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Sept 19, 9. Birthplace (State or Foreign **Funeral** Year) Mary Land 1 □ M 2 🗓 F Days Hours Min. 220-78-8614 Sept 1914 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Lutherville Director Baltimore County Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō USA 21093 300 West Seminary Avenue or Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🕅 No Specify: Specify: þ 3 XWidowed 4 ☐ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Refuse Company President 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be es 1 and 2 should be fill of Health and Mental H Soth Virginia Henry 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 424 Talbott Avenue, Lutherville, Maryland 21093 Mr. Edward Clay Stambaugh (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Jacksonville, Maryland 2/26/2008 Fairview UM Ch Cem 4 □ Donation 5 □ Other (Specify) 21. Signatura of Funcial Service Local Service Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) PNEUMONIA /Medical Due to (or as a consequence of) RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner PEMENTIA ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 No 24a. Was an this certificate has autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2X No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 □ D0A Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident Injury 1 ∏Yes 2 ∏No 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Medical

Physician Examiner Division or Vital Records, P.O. Box 68760. Hospital or Attending Physician: within 24 hours after death To the Funeral Director:

death with the Maryland

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number Dec 1373 30. Name and address of person who completed cause of death (Hen 23a) (Type, Print) OSLER DRIVE TOWSON MARYLAND X CARMODY m.D. 7601 FRANCIS 31. Date filed (Month, 32. Registrar's Signature Day, Year) ORIGINAL.

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | 1 - For State Registrar | State of N | Maryland / De C | partment of ertificate of | Health and Death | | giene 0 0 8 | 05467 | | |
|---------------------|--|-------------------------------|---|------------------------------|--|---|---|---|---------------------------|-----------------------------------|--|--|
| 7 16 | Physici | | 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year 3. Time of Death | | | | | | | | | |
| | /Medio Examir | | Angie Mae Skinn 4a. Facility Name (If not institution, given | | or) | 4b. City, Town, | or Location of De | | 4c. County of Death | | | |
| | LAGIIII | | Wilson Health C | enter | | Gaither | | | Montgom | ery | | |
| H. | Funeral | | , | | Age (In yrs. last birthd | Months Days | If Under 24 H | | 9. Birth | place (State or Foreign intry) | | |
| 764 764 | Director | | 216-46-4354 | 1□M 2∏F | 100 Yrs | - July S | 110013 | Apr 17, | | esota | | |
| | and land | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Town or | Location | | | | 10d. Inside City Limits | | |
| | Mary f sh | tor | MD Montgon | ersburg | | | 1 ☐ Yes 2 No | | | | | |
| | r 28a | lrec | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Citizen of What Cor | untry? | | |
| | th with | Completed by Funeral Director | 301 Russell Aven | | 20877 | | USA | | | | | |
| | within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-f show its Musical Examinar must be notified at | | 11. Marital Status | nt Ever in U.S. 1 s? | Was Decedent of If Yes, specify Cui | Hispanic Origin? (Specify Yes or No- can, Mexican, Puerto Rican, etc.) | | 14. Race - American Indian, Black, White, etc. | | | | |
| 36 | or II | | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced | XNo | 1 ☐ Yes 2X No | | , , | Specify: white | | | | |
| 8 | tural | | 15. Decedent's E | Year or Dates | | cedent's Usual Occu | enation | | | 6b. Kind of Business/Industry | | |
| 7. | n "na | | (Specify only highest gr | ade completed) | (G | ive kind of work done o. DO NOT use retin | during most of w | vorking | 160. Kind of Business/i | ndustry | | |
| 212 | d with | mo; | Elementary/Secondary (0-12) | College (1-4o | hor | nemaker | | | own home | | | |
| Maryland 21215-0036 | al Hygen of the last of the la | Bec | 17. Father's Name (First, Middle, Last | | | | | ame (First, Middle, | | | | |
| ylaı | Menti Menti arked | ToE | Robert John Sti | ırgeon | | | Angi | Le Hubbell | L | | | |
| Jar | 2 sh and Is m | | 19a. Informant's Name/Relationship | | | | | | r, City or Town, State, Z | p Code) | | |
| | 1 and Health am 27 thar t | | Lawrence Rensdel 20a. Method of Disposition | 1/nephew | The second secon | 62 Meadow sposition (Name of | Pond La | ne Oakton Date | VA 22124 | - Charles | | |
| Baltimore, | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Markinal Examinat must be notified at anone. | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☒ Donation 5 ☐ Other (Special | | cometant o | rematory or other pla | ace) | Date | 20c. Location - City or 1 | own, State | | |
| Balt | permit. Departimport any inj | | 21. Signature of Euneral Service Licensee Ronald S. Wade? Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 | | | | | | | | | |
| | Chysician be executed by Sician and business and business the parial-transit | ai Examiner | 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Approximate Interval Between Onset and Death Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | |
| s, P.O. Box 68760 | law requires that the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit | by Physician/Medical | F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 2art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23c. If yes, outcome of pregnancy 12d. Da Da Da Da Da Da Da Da Da Da Da Da Da | | | | | | | Day Year | | |
| rds | w require been sig should b | Completed b | Parknesses decide, Lypertensin 1 Yes 2 No 3 Probably 4 Unknown | | | | | | | | | |
| Record | о <u>г</u> б | | Otty anthritis. Anchy a | | | | | | | | | |
| Viital | i cian : Th certificate rector, pag | BeC | 25. Was case referred/to medical | or care | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | 26. Place of D | 1 ☐ Yes eath (Check only or | 2 No 1 Yes | 2□ No | | |
| > | Physician: this certifica ral director, p | ToB | examiner? 1 □ Yes 2 ☑ No | Hospital: 1 🗌 Inpa | tient 2 ER/Outpat | ient 3 DOA Ot | Other | | | | | |
| Division of | or Attending ifter death. Diractor: After in by the fune | | 27. Mann of Death 1 Vatural 5 Pending 2 Accident investigatio | 28a. Date of In (Month, E | jury 28b. Time Pay Year) Injur | | 28c. Injury at Work? 28d. Describe how in | | | | | |
| Divis | | Certification: | 3 Suicide 6 Could not be determined | street, factory, office | eet, factory, office 28f. Location (Stree City or Town, 5 | | | eet and Number or Rural Route Number, State) | | | | |
| | To the Hospital within 24 hours a To the Funaral (completely filled | edical C | 29a Certifier (Check only one) Check only one) | | | | | | | | | |
| | To the within 2. To the complet | × | 29b. Signature and title of certifier | , | / | 29c. Licen | se number | 2 | 9d. Date signed (Month | ** | | |
|) | | | 1 Lapert | buse | bland | 8 00 | 0411 | | Februare | 218,2008 | | |
| | | | 30. Name and address of person who | completed cause of | death (Item 23a) (Typ | e, Print) | 201 RI | 15871 | AVENUE | 118,2008 1 20877 | | |
| 12. 4 | | | 1 × 12 UBERI | DIKS | ttBACCT | na | 641T) | HERSB | URG, M | 11 20877 | | |
| | Sta Registr | _ | FEB 2 2 20 | | trar's Signature | ares! | | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #911 12 of Maryland Department of Health and Mental Hygierie Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** August Schmidt 13, 2008 February 5:10 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Med Ctr Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number, 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F Director 396-42-4006 71 June 21, 1936 Wisconsin Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s ~~ are injury or other traumatic event. The Maryland once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Prince George's Bladensburg 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4259 58th Street #3 20710 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Yto Yes 2 X No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: δ white 3 ☐ Widowed 4 📉 📉 vorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be ို 19a. Informant's Name/Relationship (Type. Print)
Prince George's Medical Cente 190 Mailing Address (Street and Number of Bural Route Number City of Town, State, Zip Code)
3001 HOSPITAL Drive Cheverly, MD 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in state 21. Signature of Fineral Service Licensee Rade, Director ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Part. Inter the dis-lase, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Fatal Cardiac Arrhythmia /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician use as attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 □ Pregnant at time of death 9 □ Unknown 5 ☐ Other (specify) been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy performed? Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Marther of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation To the Hospital or Automotive within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cheverly MD 20785 Drive Gar 2. Registrar's 31. Date filed (Month State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SKIPPER Month · 17 PM Josephine 2008 Chruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia **Howard County General Hospital** If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 □ M Months Days Hours Min. Director 213-28-1832 Dec 30, 1913 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director **Ellicott City** MD Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5014 Orchard Dr. 21043 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ Specify: White 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Meat Wrapper** Meat Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles A. Meldrum Amy M. Layman ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5001 Orchard Dr. Ellicott City, MD 21043 Ms.Mae M. Barth Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 □ Other (Specify) Feb 22, 2008 Marriottsville, Maryland Mount View Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Therefore the state, or complicating that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner rsician and nronic Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy Month Day 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1∐ Yes 2 NO 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 21 No 1 ☐ Inpatient မ this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manne of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 ☐ Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician; filled in by the funeral director, Director; within 24 hours a

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) FEB 2 2 2008

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sabapath

201

32. Registrar's Signature

-109

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D30641 February 19 2008
Back River Necle Road Balhmon Maylagin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Year 3.20 PM 2008 BETTY LOU teh STRAWBRIDGE /Medical Facility Name (If not institution, 4c. County of Death 4b. City, Town, or Location of Death Examiner Rehab AIr bel Air Heal Har. 120 Ju and If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 XF 215-22-8503 Director 81 30, 1926 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits show ms 23a or 28a-f shov must be notified at 1 ☐ Yes 2 No Director Maryland | Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 618 Lee Way 21014 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner muonce. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (nmn) Duff Edward Olive (nmn) Hall ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>618 Lee Way, Bel Air, MD 21014</u> <u> John E. Strawbridge / Husband</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Fintombment Bel Air Memorial Grdn 2-22-08 Bel Air, Maryland 21. Signatur Funeral Service Licensee 22. Name and Address of Facility
MCCOMAS Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Overion /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No it2 21 24a. Was an autopsy performed? Yes 2⊠No 1∐ Yes or Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Division 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D56545 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHILDI KHOLA 208 HAYS ST#102, BELAIR, MD 21014

State Registrar 31. Date filed (Month, Day, Year) FEB 2 2 2008

32. Registrar's Signature,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Brian | Wallace S | | 1- For State Registrar | e of Maryland | Departm Certific | | | Mental | | Reg | . N o. | 200 | |
|----------|---|----------------|--|--|---------------------------------------|--------------------|---|----------------------------------|--------------------|----------------------|-----------------|--------------------------------|---|
| | Physici | \$111/A | 1. Decedent's Name (First, Middle,L | · | | | | | 2. Dat _Mor | e of Death | Day | Year | 3. Time of Death 2031 hrs |
| Med 4 | lical Exami | ner | Brian Wallace S 4a. Facility Name (if not institution, g | | | | 4b. City, Town, or | ocation of De | | ruary 18 | 3, 2008 | inty of Death | |
| 3 | | | Upper Chesapeake Med | ical Center | | | Bel Air | | | | Harf | ord | |
| | Funeral | | 5. Social Security Number 6. | Sex 7. Ag | e (In yrs. last bi | rthday) | If Under 1 Year Months Days | | Hrs. 8. D | ate of Birth | (MM/DD/Y | Foreig | rthplace (State or gn |
| | Director | | 218-90-0098 | [™] M 2 F | 34 | Yrs. | | Hours | | g. 13 | 3, 19 | 73 ^{cd} | ountry Maryland |
| | ly . | | Usual Residence of Decedent 10a. State 10b. County | | 10c. City, Tow | n or Locati | ion | | | | | | 10d. Inside City Limits |
| | ow any | | , | | ,, | | | | | | | | 1 Yes 2 X No |
| | Aaryland 28a-f show 1 at once, | 흲 | Maryland Har: 10e. Street and Number | tora | B6 | el Ai | 10f. Zip Code | | | 100 | g. Citizen o | of What Cou | untry? |
| ~ | ith the Maryland 23a or 28a-f sho notified at once | Director | 2914 Pemwood Co | ourt | | | 210 | 15 | | | U | SA | |
| 162 | more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mornal Hygerian and Thealth and Mornal Hygerian and matural", or items 23a or 28a-fish unit. If item 77 is marked other than "natural", or items 23a or 28a-fish on ther traumatic event, the Medical Examiner must be notified at once in other traumatic event, the Medical Examiner must be notified at once | Funeral | 11. Marital Status | 12. Was Decedent | | | s Decedent of His | panic Drigin? | | | 14. | | rican Indian, Black, |
| | death or ite | 'nn | 1 Never Married 2 Marri | 1 Yes 2 | X No | | | | orto ratouri, | Cio., | | | hita |
| | s after ral", niocr | δ | 3 Widowed 4 Divorce 15. Decedent's Education (Specify | ed If Yes, Give Year or Dates: | nnleted) 16a | 1 | Yes 2 No | specify: | of work do | ne I | Spe 16h Kind | of Business | hite |
| | hour "natu | Completed | Elementary/Secondary (0-12) | College (1-4 or | <u> </u> | | ost of working life | | | | TOD: TAITO | 51 55 5111 6 551 | villagott y |
| | hin 736 Fi. Than than edical | Jple | Zionionia, y coconosi y (c 12) | 1 | | Sale | sman | | | | E | lectri | ical |
| | 5-003 ed withi tygiene. other th | Cou | 17. Father's Name (First, Middle, La | st) | | | | 18. Mother's Na | ame (First, | Middle, M | aiden Surr | name) | |
| | 21215-0036 21215-0036 Mental Hygiene. marked other than ic event, the Medica | Be | Wallace George | | eider | | | Linda | Mary | Kant | orsk | <u>i</u> | |
| | D 2'should and Mand Mind Mind Mind Mind Mind attice | T | 19a. Informant's Name/Relationship | | î. | | g Address (Stree | | | | | | |
| | , MD and 2 sho ealth and em 27 is traumati | | Linda Schatzschne 20a. Method of Disposition | elder / Mot | 20b. Place | 291 of Dispos | 4 Pemwoo | netery, | t, B∈ Date | | 20c. Loca | tion - City c | br Town, State |
| | imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death winner of Health and Montal Highs and The Health and Montal Highs and and I filem 37 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be | | 1 Burial 2 X Cremation | Removal from St | ate | atory or ot | | | 01 0 | | | , | |
| | Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Opparmen of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other the injury or other traumatic event, the Medinjury event | | 4 Donation 5 Other Spec 2η Signature of Funeral Service Lice | | HILL | top S | Service C | orp 2 | -21 - 0 | 8 | | son, I | Maryland |
| | Baltil permit. Departm Importa | S 22 | | | | M | Name and Address ICCOMAS F 317 Coke | uneral sbury | Home Rd | P.A Abino | A. rdon | MD 2 | 1009 |
| | Physician | | 23a. Part I. Enter the disease of co failure. List only one cause on | mplications that caused | the death. Do | not enter t | he mode of dying, | such as cardi | ac or respi | ratory arre | st, shock, | or heart | Approximate Interval Between Onset and |
| 1 | /Medical caminer | e Y | Immediate Cause (Final disease or condition resulting in death) | a. Narcotic (h | | ntoxica | ation | | | | | | Death |
| | | L | Sequentially list conditions, | b | | | | | | | | | |
| | | nine | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated | c. | equence or). | | | | | | | | - |
| | ited 1 ansit | Examiner | events resulting in death) Last | Due to (or as a cons | equence of): | | | | | | | | |
| | 0, e be executed psician and burial - transit | dical | X UNPENDED | AMENDED 27,2 | 8a-f nei | ME 08 | 77 3/5/08 ' | TT. | | | | | |
| | '60, ate be | w w | IF FEMALE: | 23c. If yes, outco | | | 11 3/3/00 | | | | 23d. D | ate of delive | ery |
| | 687 sertific iding p | ian/ | 23b. Was decedent pregnant in the past 12 months? | 1 Live birth | t time of death | - = | etal death 3 | Ectopic pre | egnancy | | Mo | nth | Day Year |
| | Sox leath c e atter for us | Physician/M | 1 Yes 2 No 9 Unkno | | t timo or dodan | 5 D | ther (Specify) | | | | | | |
| | ut the o | | Part II. Other significant condition | s contributing to dea | th but not result | ting in the | underlying cause | given in Part I. | 1 | 23e. Did to | bacco use | contribute t | to the cause of death? |
| | res the signed be de | d by | | | | | _ | | _ | 1 Yes | 2 N | o 3 Pr | obably 4 🗹 Unknown |
| | rds requi | et | | | | | | | _ [| 24a. Was a autops | sy | prior to | autopsy findings available completion of cause of |
| | eco he lav ate has age 2 : | Completed | ~ | | | | | | _ | perfor ✓ Yes 2 | | death? | |
| | an: T an: T ertificator, p | BeC | 25. Was case referred to medical | | | | 26.Plac | e of Death (Ch | eck only o | ne) | | | |
| | Vit hysical this c | 1 일 | examiner? 1 ✓ Yes 2 No | | ent 2 🗸 ER | | | | ursing Hor | | Residence | | ner: |
| | ling P | | 27. Manner of Death 1 Natural 5 Roadin | 28a. Date of Inj (Month, Day, | Year) | b. Time of | | rry at Work? Yes 2 χ No | | Describe h | ow injury | occurred | |
| | SiOr Attend death death sctor: | catic | 2 Accident Investig | ation FIR Z/IC | | FNd 7:4 | 40 pm '-eet, factory, office | | | | Street and | Number or I | Rural Route Number, City |
| | Division of Vital Records, P.O. Box 6876i tal or Attending Physician: The law requires that the death certificate is after death. Director: After this certificate has been signed by the attending plby led in by the fineral director, page 2 should be detached for use as the better the page of | Certification: | 3 Suicide 6 X Could r | not be | other s | | set, factory, office | bulluling, etc. | | or Town, St | tate) | Bel Air | |
| | Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b | edical Ce | 29a. Certifier 1 Certifying Phys | sician: To the best of r | ny knowledge, o amination and/o | death occu | urred at the time, o | ate and place, n, death occur | and due t | o the caus | e(s) and m | nanner as st | ated. |
| | To To | Mec | 29b. Signature and title of certifier | and manner stated | 1 | 5 | 29c. Licen | se number | | | 29d. Dat | e signed (N | Month, Day, Year) |
| | | | 16/211 | 11/ | . [| 11 | O.C. | M.E. | | | Febru | ary 19, 20 | 800 |
| | | | 30. Name and address of person w Zabiullah Ali, M.D. As | no completed cause of ssistant Medical E | | | nn Street, Bal | timore, MC | 21201 | | | | |
| | | tate | 31. Date filed (Month, Day, Year) | 32. Registr | ar's Signature | of and | All and | | | | | | |
| | Regis | strar | FEB 2 1 ZU | 10 P. Salar | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | S. C. Selland Con. | | - | | QCM | E | | - |

| 08-01434 | |
|--------------|--|
| Ariel Thomas | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 05472

| | | 1- For State Cer | tificate of Death | Reg. No. | 0 0011 |
|--|-------------------------------|--|---|--|--|
| Physio Medical Exar | | | | 2. Date of Death Month Day Year February 19, 2008 | 3. Time of Death 0612 hrs |
| 45 ~ | | Facility Name (if not institution, give street and number) St. Agnes Hospital | 4b. City, Town, or Location of Death Baltimore | | 7A |
| Funera Directo | | 5. Social Security Number 6. Sex 7. Age (In yrs. la | ast birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min | Forei | rthplace (State or gn ountry) |
| w any | | Usual Residence of Decedent 10a. State 10b. County 10c. City, | Town or Location Baltimore | | 10d. Inside City Limits |
| aryland | ctor | 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Cou | 1 Yes 2 No |
| th the Ms | al Dire | 2146 W. Patapsco Ave. | 21230 | Us | 5A |
| hours after death with the Maryland instural", or items $23a$ or $28a$ -f sh | by Funeral Director | | S. 13. Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto | Rican, etc.) White, etc. | rican Indian, Black, |
| 036 ithin 72 hours ene. ir than "natur | Completed by Funeral Director | | 16a. Decedent's Usual Occupation (Give kind of v during most of working life. DO NOT use reti | | /Industry |
| 21215-0 uld be filed w Mental Hygic | b Be Co | | | (First, Middle, Maiden Surname) | |
| nore, MD 21215-0036 ages 1 and 2 should be filed within 7 nt of Health and Mental Hygiene. Figure 17 is marked other than | م اڈ | 19a. Informant's Name/Relationship (Type, Print) Joanna Thomas — mother | 19b. Mailing Address (Street and Number or F | Ave. Baltimore, | Maryland |
| E & 5 = 1 | 5 | 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: | Place of Disposition (Name of cemetery, prematory or other place) | Date 20c. Location - City of Woodlawn | |
| | | 21. Signature of Furleral Service Licenson AWTH Furley AND TOTAL SERVICE SER | 3512 Frederick Ave | | |
| Physicia /Medica | ıl. | 23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line. Immediate Cause (Final disease a. Sudden unexplained) | | r respiratory arrest, shock, or heart * | Approximate Interval Between Onset and Death |
| Examine | | or condition resulting in death) Due to (or as a consequence of | | | |
| | Jiner | Sequentially list conditions, if any, leading to immediate Lause. Enter Underlying Cause |): | | |
| uted d d | Examiner | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of d. |): | | |
| 760, Teate be executed physician and the buriel francis | n/Medical | X unpended \Box amended 23a, 27, 2 | 28a-f per ME g877 3/19/2008 a | mh | |
| ∞ ≒ ≅ ; | Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant in the past 12 months? 1 Yes 2 V No 9 Unknown | 2 Fetal death 3 Ectopic pregna | 23d. Date of deliver | ry Day Year |
| P.O. Bose that the degree by the degree of t | y Phy | | esulting in the underlying cause given in Part I. | 23e. Did tobacco use contribute to | |
| ords, P.C w requires that is been signed be | | | | 1 Yes 2 No 3 Pro | bably 4 Unknown utopsy findings available |
| Division of Vital Records, lal or Attending Physician: The law require is after death. After this certificate has been sized in by the finered fractory nace 2 chould be in by the finered fractory nace 2 chould be in by the finered fractory. | 1 7 | | | | completion of cause of |
| an: T entifica | U O | 25. Was case referred to medical | 26.Place of Death (Check | | <u> </u> |
| n of Vital Recing Physician; The After this certificate | P P | 1 V Yes 2 No | | g Home 5 Residence 6 Other | er: |
| on of nding I th. | i E :: | 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury 28c. Injury at Work? | 28d. Describe how injury occurred | |
| ivisic or Atte after dea Directo | ertification: | 2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At ho | me, farm, street, factory, office building, etc. | Unknown 28f. Location (Street and Number or R or Town, State) 2146 W Pat | ural Route Number, City |
| Division of Vital Records, P.O. Box 6 To the Hospital or Attending Physician; The law requires that the death cer within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attend of the control of the finneral director for the finneral director for the finneral director and a should be deached for use. | al Cer | 29a Certifier | Columbia | Baltimore, MD | |
| To the within To the | Medical | one) 2 Medical Examiner: On the basis of examination an | nd/or investigation, in my opinion, death occurred a | it the time, date and place, and due to t | ne cause(s) |
| | Σ | 29b. Signature and title of certifier | 29c. License number O.C.M.E. | 29d. Date signed (Mo | |
| осм | 18 | 30. Name and ad reliance of person who completed cause of death (Item : Mary G. papple MD. Deputy Chief Medical Exam | • | ID 21201 | |
| | State | 31. Date filed (Month, Day, Year) 32. Registrar's Signatur | | | " |
| Regi | | FEB 2 2 2008 | ORIGINAL | | |
| OCME 2006 | | | CHICHAL | | |

State

Registrar

02/19/2008

TREIDE

31. Date filed (Month, Day, Year)

2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-00787 State of Maryland / Department of Health and Mental Hygiene Promise Taliaferro Certificate of Death 1. For State Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last) Month Day January 28, 2008 Physician/ Year 1715 hrs **Medical Examiner** Promise Taliaferro c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Country) Months Hours Min Director Jan 27, 2008 none 1 M 2 XF Maryland Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a, State Yes 2 X No s 23a or 28a-f show : Prince George's Upper Marlboro permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than ".... Director log. Citizen of What Country? 10f Zin Code 10e. Street and Number 20775 USA 1327 Ring Bill Loop 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? 1 Never Married Yes 2 X No Specify: Yes 2 X No specify: black If Yes. Give Year Divorced ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) none none none none 18.Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Felecia Taliaferro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21201 111 Penn Street Baltimore, MDO.C.M.E. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Surfice Licensee Director 23a. Park I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and List only one cause on each line. Death 'Medical a. Prematurity Immediate Quse (Final disease aminer or condition resulting in death) Due to (or as a consequence of): _{b.} Abruptio Placenta Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical AMENDED attending physician or use as the burial -UNPENDED 23d. Date of delivery Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death for use as past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 ✔ No 9 Unknown q Unknown the detached 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions Division of Vital Records, P.O. 1 Yes 2 ✔ No 3 Probably 4 Unknown \$ Completed 24b. Were autopsy findings available 24a. Was an funeral director, page 2 should prior to completion of cause of autopsy death? performed? this certificate has ✓ Yes 2 1 🗸 Yes 2 No 26.Place of Death (Check only one) thospital or Attending Physician: 24 hours after death. 25. Was case referred to medical Be Hospital: 1 Other₄ Other Residence 6 DOA Nursing Home 5 Inpatient 2 V ER/Outpatient 3 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Delivered after motor vehicle collision Certification: Jan 27, 2008 1320 hrs Yes 2 V No Natura Pending within 24 hours after death To the Funeral Director: filled in by the Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Rt. 202 & Ketting Drive, Largo, Md. Could not be Suicide determined (Specify) Local Street Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 ca Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar DHMH 17 Rev 1/2001

OCME 2006

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

January 29, 2008

Laron Locke MD. A

cel

Assistant Medical Examiner

Registrar's Signatu

E SURVEY

30. Name and address of person who completed cause of teath (Item 23a)

2008

| homas Tormo | ollan | State of Maryland / Department of the State of the State of Maryland / Department of the State of th | n nealth and Mental Hy | s Are Le ç giene | |
|---|-----------------|--|--|--|--|
| Physic V <u>edic</u> al Exam | ian ine | Registrar Certificate C | | Re 2. Date of Deat Month February 6 | |
| | | 4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital | 4b. City, Town, or Location of Death Baltimore | February 6 | 4c. County of Death |
| Funera | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | If Under 1 Year If Under 24Hrs. | 8. Date of Birt | th(MM/DD/YYYY) 9. Birthplace (State or |
| Director | | 218-85-8550 1 M 2 F 39 Yr Usual Residence of Decedent | s. Months Days Hours Min. | Nov 9 | , 1968 Foreign Countril aryland |
| ınd show any <u>ıce.</u> | | 10a. State 10b. County 10c. City, Town or Loca MD Balt | ition | | 10d. Inside City Limits 1 Yes 2 No |
| he Maryla or 28a-f | Director | 10e. Street and Number 436 N. Clinton Street | 10f. Zip Code 21224 | 10 | Og. Citizen of What Country? USA |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tien 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Funeral | 11. Mantal Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No | as Decedent of Hispanic Origin? (Spe Yes, specify Cuban, Mexican, Puerto F | ecify Yes or No- Rican, etc.) | |
| 2 hours afte "natural" Examine | ted by | or Dates: | Yes 2 No specify: nt's Usual Occupation (Give kind of wo nost of working life, DO NOT use retire | | Specify: white 16b. Kind of Business/Industry |
| 215-0036 be filed within 72 ntal Hygiene. rked other than 'ent, the Medical | Completed | Elementary/Secondary (0-12) College (1-4 or 5+) 10 0 tr 17. Father's Name (First, Middle, Last) | uck driver | | construction |
| 21215 tould be file d Mental Hy s marked o | To Be C | Lerov David Tormollan | 18.Mother's Name (Sharon A Ig Address (Street and Number or Ru | nn Pete | erson her City or Town State 7in Code |
| ages I and 2 sho on of Health and it. If item 27 is other traumati | | Leory Tormollan/father | sition (Name of cemetery, | Date | 20c. Location - City or Town, State |
| Baltimore, permit. Pages I ar Department of Hes Important: If itel injury or other tr | | 21. Donation & X Other Spacify: ip/state 21. Director St. Director Ba | Name and Address of Facility ate Anatomy Board 1timore, MD 2120 | 655 W. | Baltimore Street |
| Physician Medical xaminer | , | 23a. Fart I. Enter the distance of confer cations that caused the death. Do not enter allure. List only one cause on each line. Immediate Cause (Final disease) a. Atherosclerotic Cardiovascular Discontinuous conference of condition requires in death. | the mode of dying, such as cardiac or | respiratory arre | Approximate Interval Between Onset and Death |
| | ē | Sequentially list conditions, if any, leading to immediate Due to (or as e consequence of): b. Due to (or as a consequence of): | | | |
| nsit | Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): | | | |
| be executed sician and urial - transit | <u>_</u> | d | · · · · · · · · · · · · · · · · · · · | | |
| Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be exhin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician upletely filled in by the funeral director, page 2 should be detached for use as the burial | Physician/Medic | Pregnent at time of death | etal death 3 Ectopic pregnand | су | 23d. Dete of delivery Month Day Year |
| ords, P.O. Bov requires that the desired by the should be detached f | þ | Part II. Other significant conditions contributing to death but not resulting in the | underlying cause given in Part I. | | bacco use contribute to the cause of death? 2 V No 3 Probably 4 Unknown |
| of Vital Records, of Physician: The law require the criticate has been si meral director, page 2 should b | Completed | | | 24a. Was a autops perform | prior to completion of cause of death? |
| Vital Rec nysician: The I this certificate I director, page | To Be | 25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient | 26.Place of Death (Check on 3 DOA Other Nursing | lly one) Home 5 F | Residence 6 Other: |
| ion of tending Pheeath. | | 27. Manner of Death 1. V Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day,Year) 28b. Time of I | njury 28c. Injury at Work? 2 1 Yes 2 No | 8d. Describe h | ow injury occurred |
| Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu | Certification: | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street (Specify) | et, factory, office building, etc. | 8f. Location (Story Town, St. | treet and Number or Rural Route Number, City ate) |
| To the Hos within 24 h To the Fun completely | edical | 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigated and manner stated. | red at the time, date and place, and dition, in my opinion, death occurred at t | ue to the cause he time, date a | e(s) and manner as stated. and place, and due to the cause(s) |
| | Ž | 29b. Signature and title of certifier Denne a IN INCOME, IN ID. | 29c. License number O.C.M.E. | | 29d. Date signed (Month, Day, Year) February 7, 2008 |
| | | 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 | Penn Street, Baltimore, MD | 21201 | *** |
| St: Regist | | 31. Date filed (Month, Day, Year) MAR 1 9 2008 32. Registrar's Signature | | | |

DHMH 17 Rev 1/2001 OCME 2006

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ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

| | | | For State Registrar | State of Marylan | | rtment of tificate o | | and Mei | | iene 2 (| 008 | 05476 |
|--|--|----------------|--|---|-----------------------------------|--|-----------------------------------|-------------------------------|-------------------------------|----------------|---------------------------|--|
| | L L | | Decedent's Name (First, Middle, Last | it) | | | | 2. | Date of Death | h Day | Year | 3. Time of Death |
| | Physicia /Medic | | Margaret M. Voji | k | | | | F | eb 18, | | Toai | 2:08 p M |
| 0 | Examin | | 4a. Facility Name (If not institution, give | e street and number) | | | n, or Location o | of Death | | 4c. Count | | |
| | | | Stella Maris | 7 4 (1 | to at hitath to a | Timoni | | 24 Hm I o | Date of Dieth | Balti | | -1 (04-4 5 |
| - 10 | Funeral | | 5. Social Security Number 6. S | □M 2XIE | Yrs. | Months Da | | Min. | Date of Birth (Month, Day, | | 9. Birth | place (State or Foreign ntry) |
| | Director | | 212-03-1696 Usual Residence of Decedent | 91 | | | | 1 | 1-23-19 | 910 | | MD |
| | yland yland at | | 10a. State 10b. County | 10c. Cit | ty, Town or Loc | cation | | | | | | 10d. Inside City Limits |
| | a-f sh ified | ctor | MD Baltimo: | re Ros | edale | | | | | | | 1 ☐ Yes 2K No |
| | th the or 28, e not | Director | 10e. Street and Number | | | 10f. Zip Cod | le | | 10 | Og. Citizen of | What Cou | ntry? |
| | th wi | la | 8003 Caradock Dr | | | 21237 | | | | USA | | |
| | tems | Funeral | 11. Marital Status | 12. Was Decedent Ever in U Armed Forces? | I.S. 13. V | Vas Decedent Yes, specify C | of Hispanic Ori Cuban, Mexican | gin? (Specif n, Puerto Ric | y Yes or No- an, etc.) | | ce - Ameri ick, White, | can Indian, etc. |
| 36 | s afte ", or i | by F | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced | 1 | 1 | □Yes 2 | No Specify: | | | Speci | ^{fy:} Whi | ite |
| 8 | hour tural | | 15. Decedent's Ed | | 16a. Deced | ent's Usual Oc | cupation | | | 16b. Kind of E | | |
| 5 | in 72 "na" ra Medic | olet | (Specify only highest gra | de completed) | (Give life. L | kind of work do OO NOT use re | one during most tired) | t of working | | | | , |
| 212 | y with giene r tha the N | Completed | 12 | College (1-4or 5+) | Homem | aker | | | | Own Ho | me | |
| þ | e filed al Hyg othe vent, | Be C | 17. Father's Name (First, Middle, Last) | | | | | | irst, Middle, N | ∕laiden Surna | me) | |
| ¼. /a | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at | ToE | John Lurz | | | | Marga | aret E | Poske | | | |
| P.M | 2 sho and is ma | | 19a. Informant's Name/Relationship (| Type. Print) | | , | eet and Numbe | | | | , State, Zi | p Code) |
| 7, | and lealth m 27 her tr | | Albert Vojik/Nep | | | | ck Dr. 1 | | | | O:h T | Course Ottoba |
| 2:07 lore, | ges 1 t of H If Itel | | 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ | Removal from State | Place of Dispos cemetery, cren | natory or other | place) | Date | | 20c. Location | | |
| $2:07 \ P.M.$ Baltimore, Maryland 21215-0036 | t. Pa tmen tant: njury | | 4 □ Donation 5 □ Other (Specif | , | t Holy | | dress of Facilit | 02-21- | , | Baltim | | ome Inc. |
| Bal | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | | 21. Signature of Fineral Service Liver | isee | 1 | | lair Ro | | | | | me inc. |
| | | | 23a. Part1. Enter the disease, or com shock, or heart failure. List only | plications that caused the dea | th. Do not ente | er the mode of | dying, such as | cardiac or r | espiratory arre | est, | | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition | one cause on the horas | | 12 5 -200 | | 2/6 | 12 | | | Onset and Death |
| | /Medical | | resulting in death) | a Due to (or as a consec | quence of): | 0 | 25/1/ | 4.5 | ······ | | | |
| | Examiner | | On a serial like that one distance | h | -12/53 | | | | | | | |
| | D = | ner | if any, leading to immediate cause. Enter Underlying | Due to (or as a consec | quence of): | | | | | | | |
| 2008 | and A | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c Due to (or as a consec | | | | | | | | |
| 2c 60 , | be ex cian a | al E | | Due to (or as a consec | querice or). | | | | | | | |
| 18, 20 68760 , | physi physi | edical | | d | | | | | | | | |
| × | certiff Iding | /Me | IF FEMALE: 23b. Was decedent pregnant | 23c. If yes, outcome pf pregn | ancy | | | | | 23d. D | ate of deliv | /erv |
| AR. | atter for a | ciar | in the past 19 months? | 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of | | Ectopic pregn: Other <i>(specif</i>) | | | | | lonth | Day Year |
| P.O. Box | the c y the ached | Physician/Me | 9 Unknown | 9□Unknown | | | | | | | | |
| | s that med t | by P | Part II. Other significant conditions | ontributing to death but not res | sulting in the ur | nderlying cause | given in Part I | | 23e. Did tol | oacco use co | ntribute to | the cause of death? |
| $rac{FI}{	ext{Records}}$ | en sig | | | | | | | | 1 □ Ye | es 2□ No | 3 ☐ Pro | bably 4 Snknown |
| ပ္မ | law re as be 2 sho | Completed | Wall. | nisie N | | | | | 24a. Was a autops | V | . Were aut | topsy findings available ompletion of cause of |
| | The ate his page | ĕ | | | | | | | perform | ned? | death? 1 ☐ Yes | 2 □ No |
| IK ita | slan: ertific ctor, | Be (| 25. Was case referred to medical examiner? | | | | - | of Death (| Check only on | e) | | |
| VOJIK or Vital | hysic this co | 일 | 1 Yes 2 No | | ER/Outpatien | | | | 5 ☐ Reside | | - | ify) |
| _ | ing P | on: | 27. Manner of Death 1 Natural 5 Pending | 28a. Date of Injury (Month, Day Year) | 28b. Time of Injury | | Injury at Work? 1 ☐ Yes 2 ☐ | | d. Describe ho | ow injury occi | ırred | |
| ISIC | ttend death stor: | cat | 2 Accident investigation 3 Suicide 6 □ Could not be | | ome farm str | | | | Location (St | treet and Nun | nher or Ru | ral Route Number, |
| MARGARET Division | lor A after d Direct | Certification: | 4 Homicide determined | building, etc. (Speci | ify) | , radioly, di | | 201 | City or Town | n, State) | 1001 01 1101 | idi Hodio Hambon |
| MA | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | | | nysician: To the best of my kn | | | | | | | | |
| | he Ho in 24 he Fu pletel | Medical | one) | finer: On the basis of examin and manner stated. | ation and/or in | vestigation, in | opinion, dea | atri occurred | | · | | |
| | To t To t | Σ | 29b. Signature and title of cartifler | beste 12. | 5 | 29c. Lig | se number | 507 | 2 | 9d. Date sign | ned (Month | n, Day, Year) |
| • | . / | | 1/ | | | | | · | | ~ · · | - 0 | |
| | 5 | | 30. Name and address of person who EDDIE NAKHUDA, M | | | | DAD TT | MONTIII | M, MD 2 | 21093 | | |
| | Sta | to- | 31. Date filed (Month, Day, Year) | 32. Registrar's Sign | | | 4.4.1 | - 10 17 ± 01 | -, 110 6 | | | |
| | Sta | ne | or. Date fied (Mornin, Day, Toda) | 191 | & Lan | M. D | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1 □ M 2 🔯 F Director 556-48-2094 70 June 4, 1937 New Jersey Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21 No Director Howard Fulton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11703 Wayneridge Court 20759 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) teacher education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Millet Rose Kaminsky ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Vail/spouse 11703 Wayneridge Court Fulton, MD 20759 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Servi S. Wade, Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part Nenter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in e. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONIA **Physician** /Medical Due to (or as a consequence of): Lung CANCER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 menths? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has performed? 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation Injury To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 053987 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENCETH OPEN ABACTIMORE 31. Date filed (Month, Day, Year) 327 Registrar's Signature State FEB 2 2 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

| | | | Flease | State of Manuage | | | | - | | _ | | |
|--------------------------------|---|------------------|---|---|-----------------------|--|------------------------|--------------------------------|------------------|----------------------|---|-----|
| | | | 1 _ State | State of Maryland | | artment of r rtificate of | | мептат нус | giene | กกล | 0547 | 8 |
| | - 111 | | Registrar 1. Decedent's Name (First, Middle, Last) | | Cei | Tillicate of | Dealli | 2. Date of Dea | Reg. No | . 0 0 0 | 3. Time of Death | |
| | Physici | | | | | | | Month | Da | | | |
| 1 | /Medio | | Bonita Ann West 4a. Facility Name (If not institution, give s | reet and number) | | 4h City Town o | or Location of Deat | Feb 14, | | County of Deal | | |
| | LAGITIII | 101 | 11612 Jerome Ave. | , | , | | | ,, | | altimore | | |
| | Funeral | | 5. Social Security Number 6. Sex | 7. Age (In yrs. la. | | White Ma | If Under 24 Hrs | 8. Date of Birt (Month, Day | | | hplace (State or Fore | ign |
| | Director | | 219-30-1/01 | ^{M 2} ♥ 56 | Yrs. | Months Days | Hours Min. | 01-09-1 | y, year) 1952 | Co | MD | |
| | pu. | | Usual Residence of Decedent 10a. State 10b. County | 10. 65 | Ţ | | | | | | | |
| | aryla •ho | ō | | | Town or Lo | | | | | | 10d. Inside City Limi | |
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| | with a | 급 | 11612 Jerome Ave. | | | 10f. Zip Code | | | | izen of What Co | ountry? | |
| | within 72 hours after death with the Maryland ene. Than "natural", or Iteme 23a or 28a-f ehow Ite Madical Examiner must be notified at | Funeral Director | | 2. Was Decedent Ever in U.S. | 13) | 21162 | lispanic Origin? (9 | pecify Ves or No. | | SA 14. Race - Ame | nican Indian | |
| (0 | iffer of the second | 듄 | 1 ☐ Never Married 2 ☑ Married | Armed Forces? 1 ☐ Yes 2 X No | | Was Decedent of H If Yes, specify Cuba | | o Rican, etc.) | | Black, Whit | e, etc. | |
| က္ထ ဇ | ral', c | Ď | 3 Widowed 4 Divorced | If Yes, Give Year or Dates: | | 1□Yes 2∰ No | Specify: | | | Specify: Whi | te | |
| 5 - - | 72 hg | Completed by | 15. Decedent's Educ (Specify only highest grade | ation completed | 16a. Deced | dent's Usual Occup | ation | rking | 16b. K | ind of Business | | |
| 7 | of thin | dr. | Elementary/Secondary (0-12) | College (1-4or 5+) | life. | DO NOT use retired | d) | King | | | | |
| 2 | led w lygier her ti | S | 12 | | Hon | nemaker | | | | n Home | | |
| and | tati A of ot | Be | 17. Father's Name (First, Middle, Last) | | | | | ne (First, Middle, | | | | |
| Ĕ | d Me d Me nark | ဥ | Joseph V. Burke S | | | | | Edna Tre | | - | | |
| ≅ | d 2 s th an th an traur traur | | Charles E. West J | | | ng Address (Street | | | | | Zip Code) | |
| ē, | Heal Heal tam other | | 20a. Method of Disposition | | | 2 Jerome . sition (Name of matory or other place | | ite Mars Date | | cation - City or | Town. State | |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If term 271s marked other than "natural; or Iteme 23a or 28a-1 show eny injury or other traumatic event, the Marical Examinar must be notified a once. | | t ⊠ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) | movar nom orato | netery, cren 1y Hi | | 1 | 8-2008 | | timore 1 | | |
| ₩ | iniu mit | | 21. Signature of Funeral Service License | | | L.L. . Name and Addre | | | | | | - |
| ä | Depermine Depe | | > Set the | 9 | | 705 Belai | | Nottingh | | MD 212 | _ | |
| | | | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one | ations that caused the death. | | | | | | | Approximate Interval Between | |
| F | hysician | | | Onset and Death | | | | | | | | |
| | /Medical | | disease or condition resulting in death) | Due to (or as a conseque | | ILUre | | | | | Jyrs. | |
| | Examiner | | Sequentially list conditions b. | | | | | | | | | |
| 7 | sit so | Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conseque | nce of): | | | | | | | |
| | and I-tran | хап | that initiated events resulting in death) Last | Due to (or as a conseque | nno ot): | | | | | | | _ |
| . 60 | te be executed ysicien and e burial-transit | cal E | | Due to (or as a conseque | nice or). | | | | | | | |
| 687 | earn certificate be executed attending physicien and for use as the burial-transit | | d. | | | | | | | | | - |
| × | nding use a | √Me | IF FEMALE: 23b. Was decedent pregnant | c. If yes, outcome of pregnance | ;y | | | | | 23d. Date of del | | |
| m į | a atte | clai | in the past 12 months? 1 □ Yes 2 ▼No | 1 Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat | | Ectopic pregnancy Other (specify) | | | | Month Month | Day Year | |
| P.O. Box | by the | Physician/Med | 9 □ Unknown | 9□ Unknown | | | | | | | | |
| ν̈́. | ine law requires mai me deam dermica ele has been signed by the attending ph page 2 should be detached for use as th | by P | Part II. Other significant conditions cont | ibuting to death but not resulti | ing in the ur | nderlying cause give | en in Part I. | 23e. Did to | bacco u | se contribute to | the cause of death? | |
| 2 | been signature | Completed by | CHF | | | | | 1 🗆 Y | es 2 | □No 3□Pr | obably 4 nknov | vn |
| ပ္တ | has be | pie | PLEUTALEF | FUSIONS | | | | 24a. Was a | | 24b. Were au | topsy findings availab completion of cause o | ole |
| ¥ , | ete h | 10C | | | | | | perfor | med? | death? | 2 No | |
| <u> </u> | ertific actor, | Be | 25. Was case reterred to medical examiner? | | | | | th (Check only or | ne) | | - | |
| 0 | | ဥ | 1 165 21 10 | spital: 1 Inpatient 2 EF | | | 4 Nursing n | ome 5 Resid | | | cify) | |
| ב | After | ion | 27. Manner of Death 1 Natural 5 ☐ Pending | 28a. Date of Injury (Month, Day Year) | 8b. Time of Injury | Worl | | 28d. Describe h | ow injur | y occurred | | |
| Division of Vital Records, | after death. Director: After th | lica | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be | 28e. Place of Injury - At home | e farm etre | | Yes 2 □No | 29f Location /C | tenat on | d Mumbas as Di | m / Do do Alemba | |
| | 5 4 7 5 | Certification; | 4 Homicide determined | building, etc. (Specify) | o, iaiii, siie | et, factory, office | | City or Town | n, State |) | ral Route Number, | |
| - | within 24 hours E | | 29a. Certifying Physi | cian: To the best of my knowle | edge, death | occurred at the tim | ne, date and place | and due to the c | ause(s) | and manner as | stated | |
| - | Fu Fulletel | edicai | (Check only 2 Medical Examine one) | r: On the basis of examination and manner stated. | n and/or inv | estigation, in my of | oinion, death occu | rred at the time, d | late and | place, and due | to the cause(s) | |
| | | ŽΪ | 29b. Signature and title of certifier | NICK MEYLIS | MA | 29c. License | number | 2 | 9d. Dat | e signed (Monti | n, Day, Year) | |
| | within 24 hours at To the Funeral Completely filled | | | | | i | | | | | | |
| 6 | withir To th comp | | | TIENDING PHY | SICIA | n D004 | 7762 | | 2 | 15/8 | | |
| A. | Within To the comp | | 30. Name and address of person who com | pleted cause of death (Item 2 | За) (Туре, Г | Print) | | | | /_/_ | | |
| (| odwoo Stal | | | pleted cause of death (Item 2) | 3a) (Type, F | Print) | 7762 non iun | 1 Md | | /_/_ | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 1815 PM Micheal Williams ASKew February 2008 19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner NA Harbor Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) MISSOWI 7. Age (In yrs. last birthday) **Funeral** Months Hours Days 1 M 2 F 486-78-8275 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the M-dical Examiner must be notified at 10d. Inside City Limits 1 Pres 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital States 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Musiciar 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Herstchal Brenda Williams ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) St. Louis Williams -(Ma Missouri 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 ☐Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-transi attending physician and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death ed by the a detached f 9☐Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown After this certificate has keen si funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2∭ Mo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation (Month, Day Year) Natural within 24 hours arren community to the Funeral Director: Aff 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Doctor Res 001 february 19,2008

State

Sairah Bashir 31. Date filed (Month, Day, Year)

32. Registrar's Signature

South

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

Registrar FEB 2 2 200

Hanover Street, Baltimore, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| | | | State of Maryland / D | Department of I | | | iene | 8 05480 | |
|---------------------|---|----------------|---|---|--|---|---|---|--|
| | Physici | | 1. Decedent's Name (First, Middle, Last) Joanne Hill West | | | 2. Date of Deat | | 3. Time of Death 00:20 M | |
| | */Medio Examir | | 4a. Facility Name (If not institution, give street and number) | | or Location of Deatl | | 4c. County of Death | | |
| | Funeral | | Carroll Hospital Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birtle) | | minster If Under 24 Hrs. | 8. Date of Birth | Carrol1 9. Birth 9. Birthplace (State or Foreign | | |
| .22,-1 | Director | | 241-80-9632 1 M 2 XF 61 | Yrs. Months Days | Hours Min. | 8. Date of Birth (Month, Day, Jan 17, | 1947 | Country) NC | |
| | yfand Iow at | | Usual Residence of Decedent 10a. State 10b. County 10c. City, Town | or Location | | | | 10d. Inside City Limits | |
| | he Mar 8a-f sk otified | Director | | dersburg | | | | 1 □Yes 2 No | |
| | h with t 3a or st be n | | 792 Sussex Court | 10f. Zip Code | 21784 | 10 | 0g. Citizen of What USA | Country? | |
| 36 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral | 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: | 13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🕅 No | | pecify Yes or No- o Rican, etc.) | 14. Race - A Black, W Specify: | | |
| Maryland 21215-0036 | nin 72 hou In "natura Medical E | Completed | 15. Decedent's Education 16a. I | Decedent's Usual Occu (Give kind of work done life. DO NOT use retire | pation during most of wor | king | 16b. Kind of Busine | ss/Industry | |
| 212 | led with lygiene her tha nt, the I | | 2 | Sales Dire | T | | John Deer | re | |
| anc | ild be fi lental H ked otl ic ever | To Be | 17. Father's Name (First, Middle, Last) Leon Kenneth Hill, Sr. | | | ne <i>(First, Middle, N</i> or Beatri | | | |
| lary | 2 shour and M is mar raumat | - | 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 | Mailing Address (Street | | | | | |
| ē, | s 1 and f Health tem 27 other t | | 20a. Method of Disposition 20b. Place of | 33 Old Crew Disposition (Name of y, crematory or other pla | | | , NC 2754 20c. Location - City | | |
| Baltimore, | Page ment o ant: If ury or | | I Duliai 24E Ciellation 3 Dinemoval Iron State | unty Crematory or other pla | 1 | /2008 | Sykesvill | e, MD | |
| Ball | permit. Depart Import any Inj once. | | 21. Signature of Funeral Service Licensee Suc L Haugit Mco 264 | HAIGHT FU Sykesvil | NERAL HOM 1e, MD 21 | E & CHAP: 784 | EL, P.A. | (Box 195) | |
| | Physician | | 23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition | ot enter the mode of dyi | ng, such as cardiad | or respiratory arre | est, | Approximate Interval Between Onset and Death | |
| | /Medical Examiner | | resulting in death) Due to (or as a consequence of | f): | | | | - Marie | |
| | p ## | iner | Sequentially list conditions, if any, leading to immediate gause. Enter Underlying | d): | | | | | |
| 5 | icate be executed physician and s the burial-transit | Examiner | that initiated events resulting in death) Last C | f): | | | | | |
| 09/80 | ficate be physicials the bu | dical | d | | | | | | |
| C. BOX | w requires that the death certificate been signed by the attending physi should be detached for use as the | Physician/Me | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown | 3 □Ectopic pregnanc 5 □ Other (specify) _ | y | | 23d. Date of o | delivery Day Year | |
| cords, P. | requires that een signed by nould be deta | by | Part II. Other significant conditions contributing to death but not resulting in | the underlying cause giv | ven in Part I. | 23e. Did tob | | to the cause of death? Probably 4 100000000000000000000000000000000000 | |
| T T | The la ate has page 2 | Completed | | | | 24a. Was an autopsy perform 1∐ Yes 2 | y prior | | |
| VII | Physician: r this certific ral director, | Be | 25. Was case referred to medical examiner? 1 ☐ Fes 2☐ No Hospital: 1 ☐ Inpatient 2 ☐ FeVOuts | patient 3 DOA Oth | ner | th (Check only one | | • | |
| lon or | To the Hospital or Attending Physician: whithis 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director, | ation: To | 27. Manner of Death 28a. Date of Injury 28b. Ti | ime of 28c. Inju | | 28d. Describe ho | nce 6 □Other (S w injury occurred | респу) | |
| DIVISION | To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral processor. | Certification: | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farr building, etc. (Specify) | m, street, factory, office | | 28f. Location (Str City or Town | reet and Number or , State) | Rural Route Number, | |
| | re Hospi 124 hou re Funer iletely fill | Medical | 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated. | death occurred at the ti l/or investigation, in my | me, date and place opinion, death occu | , and due to the ca rred at the time, da | ause(s) and manner ate and place, and c | as stated. due to the cause(s) | |
| _ | To th To th comp | Me | 29b. Signature and title of certifie | 29c. Licens | se number | 29 | 9d. Date signed (Mo | onth, Day, Year) | |
| • | / | | 30. Name and address of person who completed cause of death (Item 23a) (T | [voe, Print) | 519 14 | Fe | proord | 19,7008 | |
| | り | | Herbort P. Henderson J. 2973 Ma | inchester | RJ Ma | nc hest | W MD | 21102 | |
| | Sta Registr | | 31. Date filed (Manth, Day, Year) 2008 | | | | , | | |

DHMH 17 Rev 1/2001

Certificate of Death

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| 4 | /Medic | al | |
| | Examin | er | 4a. |
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| [a | Funeral | 1 | 5. S |
| | Director | | 48 |
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| | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | To Be Completed by Funeral Director | 4a. 5. S 4 4 10a Ma 10a 5. 11. |
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| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monce. | 2 | 17. 198 Ka |
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| | Physician /Medical | 11 | Imr dis res |
| | Examiner | | . 50 |
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| | cuted nd . | aminer | Sec if a Car Car tha |

| n | 1. Decedent's Name (F | | Pearl V. | Wolfe | | | | 2. Date of De Month Februa | | 2008 | 3. Time of E | | | |
|---|---|--|--|-------------------|-------------|---------------------------------------|-----------------------------------|----------------------------------|--------------------------------|----------------------------------|---|--------------------|--|--|
| al | 4a. Facility Name (If no | | | | | 4h City Tayon | al coeffice of Do | i | | | 10:45 | AW | | |
| er | 5480 Wisco | . 0 | , | | | 4b. City, Town, o | y Chase | atn | | nty of Death | | | | |
| | 5. Social Security Num | | | e (In yrs. last t | oirthday)_ | If Under 1 Year | - | rs. 8. Date of Bi | rth | ntgome 9. Birthp | ace (State or | Foreian | | |
| | 481-52-974 Usual Residence of De | / |]M 2⊠F | 91 | Yrs. | Months Days | Hours Mi | n. June 9 | , 1916 | Coun | nesota | | | |
| | | Db. County | | 10c. City, To | wn or Loc | ation | | | | 1 | 0d. Inside City | / Limits | | |
| 5 | Maryland : | Montgome | ry | | (| Chevy Ch | ase | | | | 1 ⊠Yes | 2 🗌 No | | |
| | 10e. Street and Number | er | | I | | 10f. Zip Code | | | 10g. Citizen of What Country? | | | | | |
| 3 | 5480 Wisco | nsin Ave | nue #825 | | | 20 | 815 | | Unite | d Stat | es | | | |
| completed by I uneral Director | 11. Marital Status 1 ☐ Never Married | | 12. Was Decedent I Armed Forces? 1 Yes 2 🔯 N | | | /as Decedent of I Yes, specify Cub | |)- 14. F | Race - Americ Black, White, | etc. | | | | |
| 2 | 3 ☑ Widowed 4 ☐ | Divorced | If Yes, Give Year or Dates: | | 1 | □Yes 2 ⊠ No | Specify: | | Spe | cify: Wh | ite | | | |
| | 15 (Specify | . Decedent's Educ only highest grade | cation completed) | 16 | a. Decede | ent's Usual Occu aind of work done | pation | vorkina | 16b. Kind o | f Business/Inc | dustry | | | |
| É | Elementary/Seconda | | College (1-4or 5 | i+) | life. D | O NOT use retire | d) | TOTKING | | | | | | |
| | | | | | Нот | nemaker | Υ | | Own Home | | | | | |
| | 17. Father's Name (Fir. | | | | | | l | ame (First, Middle | | , | | | | |
| Peter J. Peterson Caroline B. Grethen 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co. | | | | | | | | | | | | | | |
| | 19a. Informant's Name Karen Soll | | , | 4 | 601 i | | | #01, Chev | | | | 2081 | | |
| | 20a. Method of Disposi 1 🖾 Burial 2 □ C 4 □ Donation 5 [| Premation 3 □R | cuary 23, 2008 | y 23, $G = 1$ | | | | | | | | | | |
| | 21. Signature of uner | ral Service License | Home/ | | | vy • | | | | | | | | |
| 1 | 23a. Part1. Enter the c shock, or heart fa | disease, or compli | cations that caused | the death. Do | | | | | | 20814 | Approximate | | | |
| | Immediate Cause (Fin. | | | | | | | | | | Interval Betw Onset and De | eath | | |
| | disease or condition resulting in death) | a a | | a consequence | | n Dissec | tion | | | <u>I</u> : | mmedia | te | | |
| l | | | | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of): | | | | | | | | | | | | | | |
| Cause. Enter Underlying Cause (Disease or injury that initiated events C. | | | | | | | | | | | | | | |
| l | resulting in death) Last | ľ | Due to (or as | a consequence | e of): | | | | | | | | | |
| Due to (or as a consequence of): cause. Ente: Uniderlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): d. Due to (or as a consequence of): d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome pf pregnancy 1 | | | | | | | | | | | | | | |
| 1 | IF FEMALE: | | | | | | | | | | | | | |
| | 23b. Was decedent pro in the past 12 mo 1 ☐ Yes 2 🛣 N 9 ☐ Unknown | onths? | 3c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown | 2 Fetal dea | | Ectopic pregnand Other (specify) _ | | | | 23d. Date of delivery Month D | | ear | | |
| | Part II. Other significa | nt conditions con | tributing to death bu | ut not resulting | in the und | derlying cause giv | ven in Part I. | 23e. Did | tobacco use c | ontribute to th | ne cause of de | eath? | | |
| | Atheroscl | | - | - | | | | | Yes 2 🔀 No | | | | | |
| | | | | | | | | 24a. Was auto perfe | | prior to cor death? | psy findings a npletion of cal | vailable use of | | |
| | 25. Was case referred | to medical | | | | | 26 Place of P | 1 Yes eath (Check only | | 1 ☐ Yes | 2□No | | | |
| | examiner? 1 24 Yes 2 □ No | | lospital: 1 ☐ Inpatie | nt 2□ER/C | Outnatient | 3□ DOA Oth | | Home 5 A Res | | Diban (Casa) | | | | |
| 1 | 27. Manner of Death | | 28a. Date of Inju | ry 28b | . Time of | 28c. Inju Wo | | 28d. Describe | | | ·// | | | |
| I | 1 Anatural 5 2 Accident | 5 ☐ Pending investigation | (Month, Day | / Year) | Injury | | rk? Yes 2∐No | | to now injury occurred | | | | | |
| | | 3 Suicide 6 Could not be 28e. Place of injury - At h | | | | | me, farm, street, factory, office | | | | 28f. Location (Street and Number or Rural Route Number, City or Town, State) | | | |
| | 29a. Certifier (Check only and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | | | | | | | | | | | | | |
| | 29a. Certifier 12 (Check only 2 one) | Certifying Phys Medical Examir | ner: On the basis of and manner sta | examination a | and/or inve | estigation, in my | opinion, death o | curred at the time | , date and plac | ce, and due to | the cause(s) | | | |

State

Registrar

31. Date filed (Month, Day, Year)

FEB 22

Division or Vital Records, P.O. Box 68760,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 20, 2008 **Physician** Irene Mildred Williams 6:00 A M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Collingswood Nursing Home Rockville Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 X F 324-44-4018 90 **Director** April 22, 1917 Illinois Usual Residence of Decedent show 10a. State 10c, City, Town or Location r 28a-f show notified at 10d. Inside City Limits 1 X Yes 2 No Maryland | Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 15303 Gable Ridge Court Apt. C 20850 death v United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: à Specify: White 3 ☐ Widowed 4 🕅 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 h Elementary/Secondary (0-12) College (1-4or 5+) Manager Sears marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fi h and Mental H 7 is marked ot Be traumatic Charles Preston Kidwell Inez Dant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health ar Important: If item 27 is any injury or other trau Mary K. Williams/Daughter 15303 Gable Ridge Court Apt. C, Rockville, MD 20850 20b. Place of Disposition (Name of Gate of Heaven 20a. Method of Disposition 20c. Location - City or Town, State February 1 Burial 2 □ Cremation 3 Removal from State etery 25, 2008 Silver Spring, MD

22 Name and Address of Facility Rolert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave.

Bethesda, Maryland 20814 4 □ Donation 5 □ Other (Specify) Cemetery 21. Signature of Euneral Service Licenses M01346 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Sepsis /Medical Due to (or as a consequence of): Examiner Failure to Thrive Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) death certificate be executed burial-trar Due to (or as a consequence of): physician Physician/Medical the IF FEMALE If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s has autopsy performed? Yes 2X No certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation Injury 1 ∏Yes 2 ∏No 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Box 68760, P.O. Division or Vital Records, the Hospital or Attending I hin 24 hours after death. the Funeral Director: After

Baltimore, Maryland 21215-0036

2

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sayed Elsayyad, M.D.

and manner stated.

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

29a, Certifier

(Check only one)

2008 22 FEB

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

00062435

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| | | | 1 - For State Registrar | Oldic Or I | Ce | ertificate of | | , , | g. No. 2 (1 (1 8 | 0.54.83 | | |
|------------|--|-------------------|---|--|--|---|--|---|---|--|--|--|
| Г | Physici | an | 1. Decedent's Name (First, Middl | | | | | Date of Death Month | Day Year | 3. Time of Death | | |
| 1 | /Medi | | KENDALL | | | WILHIOL | | FEBUARY | 18 2008 | 0012 AM | | |
| | Examir | er | 4a. Facility Name (If not institution | | , | 4b. City, Town, o | r Location of Death | | 4c. County of Dea | | | |
| | | K | 5. Social Security Number | ve Adventist Ho | ospital Age (In yrs. last birthday | /) If Under 1 Year | Rockville If Under 24 Hrs. | 8 Date of Birth | | ntgomery | | |
| b | Funeral Director | | 220-82-6609 Usual Residence of Decedent | 1 M 2□F | 41 Yrs. | Months Days | Hours Min. | 8. Date of Birth (Month, Day, Nov 9 | | thplace (State or Foreign ountry) MD | | |
| | land ow | | 10a. State 10b. County | | 10c. City, Town or L | ocation | <u></u> | | | 10d. Inside City Limits | | |
| | he Man 28a-f sh otified | Director | | lontgomery | | | Germantown | | | 1 □Yes 2/No | | |
| | ath with t s 23a or 2 nust be n | ral Dir | 10e. Street and Number 19706 Crystal Rock | | | 10f. Zip Code | 20874 | | | S.A. | | |
| 21215-0036 | be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral | 11. Marital Status 1 Never Married 2 Mari 3 Widowed 4 Divorced | ied 12. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates | No | . Was Decedent of H If Yes, specify Cub | dispanic Origin? (Spe an, Mexican, Puerto Specify: | cify Yes or No- Rican, etc.) | 14. Race - Am Black, Whi | | | |
| 5-0 | 72 ho 'natur dical | Completed | 15. Deceden (Specify only highe | t's Education st grade completed) | 16a. Dec | edent's Usual Occup | ation during most of working | na 1 | 6b. Kind of Business | /Industry | | |
| 121 | within iene. than " | ď | Elementary/Secondary (0-12) | College (1-4o | or 5+) | | during most of workii d) | .9 | _ | | | |
| 2 | filed v Hygie ther t | | 12 17. Father's Name (<i>First, Middle,</i> | (act) | | Delive | ery Person 18. Mother's Name | /First Middle 14 | · | etail | | |
| Maryland | uld be f fental F rked of tic eve | o Be | 17. I amer s Name (First, Middle, | Leon E. Whil | lhida Ir | | 16. Wourier S Mairie | | | | | |
| IZ | should be ind Mental i marked umatic ev | 욘 | 19a. Informant's Name/Relations | | | ling Address (Street | and Number or Bura | | Beverly Marsh Route Number, City or Town, State, Zip Code) | | | |
| Ma | d 2 th a tra | | Mr. Lee Wilhide | Father | I | | Dr. The Villa | | | 21p 00de) | | |
| ē, | s 1 and sift Health item 27 other tr | | 20a. Method of Disposition | | 20b. Place of Disp | | , D | | Oc. Location - City o | Town, State | | |
| Baltimore, | permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other | | 1 Burial 2 □ Cremation 1 □ Donation 5 □ Other (S | 3 □ Removal from State (specify) | te | e Park Cemete | · | 21, 2008 | Baltimor | e, Maryland | | |
| alti | permit. Departrimporta Importa any Inju | , | 21. Sign Jure of Full ral Service | Licente / | | 22. Name and Addre | | .,, | Danimo | o, maryiana | | |
| m | an In Co | 1 | Mandelle | Sleh | ld- | Slack Fu 3871 Ok | ineral Home, P 1 Columbia Pik | .A. e Ellicott Cit | v MD 21043 | | | |
| | | <u></u> | 23 Part1. Enter the disease or shock, or heart failure List | complications that caus | ed the death. Do not er line. | nter the mode of dyir | ng, such as cardiac o | r respiratory arre | st, | Approximate Interval Between | | |
| | Physician | | In mediate Cause (Final Isease or condition | ACUT | E MYOCAR | DIAL IN | FARCTION | | | Onset and Death | | |
| | /Medical Examiner | , | resulting in death) | Due to (or a | as a consequence of): | | | | | | | |
| þ | Examiner | | Sequentially list conditions, | b | | | | | | | | |
| | B/X # | ine | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or a | as a consequence of): | | | | | | | |
| | icate be executed | Examine | that initiated events resulting in death) Last | c | as a consequence of): | | | | | | | |
| 60 | be e sician buria | ᇛ | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | | | |
| 68760, | certificate be executed thing physician and ise as the burial-transit | edic | | d | | | | | | | | |
| P.O. Box | death e atter d for u | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown | , | 23d. Date of delivery Month Day | | | | | | |
| | s that ned b | by Pi | Part II. Other significant condition | ons contributing to death | but not resulting in the | underlying cause giv | en in Part I. | 23e. Did toba | acco use contribute t | the cause of death? | | |
| ğ | quire en sig uld b | | ALUTE COREBR | OVASCULAR | ACCIDENT | | | 1 ☐ Yes | 3 2 No 3 □ P | robably 4 🗹 Unknown | | |
| Records, | The law requires that the ate has been signed by the bage 2 should be detache | Completed | ISCHEMIC CARL | HTAGUYMON | 17 | | | 24a. Was an autopsy | prior to | utopsy findings available completion of cause of | | |
| | icate r, pag | | | | | | | perform 1□ Yes 2 | I No 1 □ Ye | 3 2 1 No | | |
| or Vital | Physician: r this certific ral director, I | Be | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No | Hospital: | V1 0750/04-V- | ont 317 DOA Oth | 26. Place of Death er: | | | | | |
| ō | ding Physician; The lav n. After this certificate has funeral director, page 2 | <u>د</u> | 27. Manner of Death | 28a. Date of Ir | itient 2 ☐ ER/Outpatie | III JUDON | 4 □ Nursing Hon | ne 5 Resider | nce 6 Other (Spe | ecify) | | |
| on | nding th. ; Afte fune | tion | 1 ☑ Natural 5 ☐ Pendin 2 ☐ Accident investig | g (Month, E | Day Year) Injury | Wor | k? Yes 2 □ No | | vinjary occurred | | | |
| Division | Attending It death. ector; After by the fune | Certification: | 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ | not be 28e. Place of i | njury - At home, farm, si etc. <i>(Specify)</i> | | | | et and Number or F | ural Route Number, | | |
| Õ | s after s after at Dir | Sert | 4 Difficial | building, | екс. (Зреспу) | | | City or Town, | State) | | | |
| | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the | edical (| 29a. Certifier 1 | g Physician: To the bes Examiner: On the basis and manner | of examination and/or i | th occurred at the tin nvestigation, in my o | ne, date and place, a ppinion, death occurre | and due to the cau ed at the time, da | use(s) and manner a te and place, and du | s stated. e to the cause(s) | | |
| | To the within To the comp | Me | 29b. Signature and title of certifie | | | 29c. Licens | e number | 29 | d. Date signed (Mon | th, Day, Year) | | |
|) | | | Manan | ı | | | 2562 | F | EBUARY | 18 5008 | | |
| | Ų | | 30. Name and address of person MADNAV(KUみらく / | | death (Item 23a) (Type | | E ROCKE | illi m | ARYLAND | 20850 | | |
| | Sta Registr | | 31. Date filed (Month, Day, Year) FFB 2 2 2008 | N- | strar's Signatur | , | | | | | | |
| | | | LEDUR COR | The state of the s | 9 | | | | | | | |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Zellne 2000 COVHE /Medical 4a. Facility Name (ff not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 15altimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign Date of Birth (Month, Day, Year) **Funeral** Months Davs Hours Director 215-10-5500 89 MD Jul 12, 1918 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show Medical Examiner must be notified at Director MD 1 ∐ Yes 2**/∑**No Cecil **Perry Point** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Perry Point Va Medical Center** 21902 death v U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2□ No 7/9/1941 Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White 9/24/1945 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. int: If item 27 is marked other than " ury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Technician **County Government** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Zellmer Catherine Ann Sewell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Rockenbaugh Sister 2417 Westchester Ave Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation permit. Page Department o Important: If a 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. John's Lutheran Church Columbia, MD 21. Signature of Funeral Sand 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Soler the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Latracianial /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ician and burial-trans Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No for Month Year Dav 5 ☐ Other (specify) ed by the a detached f 9 🗆 Unknown cate has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perforn certificate 2 □ No 1∐ Yes To the Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 Natural 5 Pending death. 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only 29b. Signature and title of certifier

State Registrar

South

MI

32. Registrar's Signature

22

30. Name and address of per in who completed cause of death (Item 23a) (Type, Print) an

/ucci

ORCI

Year.

31. Date filed (Month, Day,

| 08-00995 | |
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| Camaran | Achanti |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

| amorom you | 10 | 1- For State Registrar | | ficate of | | na ivien | iai nygierie | Reg. No | 200 | 8 0548 |
|--|----------------|---|---------------------------|------------------|------------------------|---|-----------------------------------|---------------------|--------------------------------|---|
| Physici | | 1. Decedent's Name (First, Middle,Last) | | | | | Date of D Month | eath | | 3. Time of Death |
| ledical Exam | iner | CAMERON JAMAL ASHA 4a. Facility Name (if not institution, give street and number) | | | o. City, Town, | or Longtion o | Month Februar | | 08 c. County of Death | 1023 hrs |
| | | Peninsula Regional Medical Center | | 41 | Salisbury | or Location c | or Death | | C. County of Death Wicomico | |
| Funeral Director | | | e (In yrs. last | birthday) | If Under 1 Ye | ear If Unde | | Birth(MM | //DD/YYYY) 9. Bir Foreig | in. |
| Director | | 212-57-0927 1X M 2 F Usual Residence of Decedent | 8 | 8 Yrs. | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Nov. | 10, | 1999 ^c | untry) MD |
| any | | 10a. State 10b. County | 10c. City, To | wn or Locatio | n | | | | | 10d. Inside City Limits |
| Aaryland 28a-f show 1 at once. | or | Maryland Wicomico | Salis | bury | | | | *** | | 1 Yes 2 X No |
| th the Maryland 23a or 28a-f sho | Director | 10e. Street and Number | | | 10f. Zip Code | | | 10g. Cit | tizen of What Coul | ntry? |
| more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland near of Heath and Mental Hygien and in the Heath and Mental Hygien and int. If item 27 is marked other than "natural", or items 23a or 28a-f she in their traumatic event, the Medical Examiner must be notified at once | | 650 Suffolk Court 11. Marital Status 12. Was Decedent | Ever in U.S. | 13. Was | 21801 Decedent of F | | in? (Specify Yes or | No- | USA 14. Race - Ameri | can Indian, Black, |
| death wi | Funeral | 1 X Never Married 2 Married Armed Forces? 1 Yes 2 | X No | If Ye | s, specify Cub | an, Mexican, | Puerto Rican, etc.) | | White, etc. | |
| hours after "natural", Examiner | þ | Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade con | naloted) 16 | | Yes 2X N | | kind of work done | lach | Specify: Bla | |
| 72 houn | Completed | Elementary/Secondary (0-12) College (1-4 or | | | st of working li | | | 100. | Kind of Business/ | ndustry |
| 5-0036 led within 72 Hygiene. other than the Medical | ldu | 2nd | | studen | t | | | | | |
| 215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica | Be Cc | 17. Father's Name (First, Middle, Last) David Emieke Johnson | | | | | s Name (First, Midd a Zakiyya) | | | |
| 212 ould be J Ment s mark | To B | 19a. Informant's Name/Relationship (Type, Print) | 1 | 19b. Mailing | Address (Str | | ber or Rural Route I | | | , Zip Code) |
| MD nd 2 sho alth and m 27 is | | Aesha Johnson/mother | | | | | Salisbury, | | | 801 |
| Baltimore, MD 21215-003 permit. Pages I and 2 should be filled within Opparment of Health and Mental Hygiene. Important: I firen 27 is marked other It niqury or other traumatic event, the Med | | 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from Sta | ate crer | matory or othe | . , | | Date | İ | Location - City or | |
| I ltim nit. Pa artmen ortant ry or o | | 4 Donation 5 Other Specify: 21. St@nature of Funeral Service Licensee | Spring | | em. Go | | 02/9/2008 1213 Jers | | ebron, Ma | aryland |
| Ba Pem Dep Dep | | Palricia a Jolles | 1 | Jol | ley Me | morial | Chapel, F | ey r .A. | oau, San | 21801 |
| Physician /Medical | | 23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line. | | | | | | | | Approximate Interval Between Onset and |
| aminer | | Immediate Cause (Final disease or condition resulting in death) a. Complicatio Due to (or as a const | | rinatal | hypoxic | -Ischem | ic encephal | orathy | - | Death |
| | | Sequentially list conditions, | squerice or). | | | | | | | |
| | iner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated c. | equence of): | | | | | | | |
| ped sit | Examin | (Disease or injury that initiated events resulting in death) Last | equence of): | | | | | | | |
| execut an and al - tran | | UNPENDED d. | O.7- | 7 0 /11 /0 | | | | | | |
| 760, cate be ex physician he burial | Medical | IF FEMALE: 23c. If yes, outcor | rME,g8// ne of pregnan | / 2/11/00 ncy | 8 TT | | | 23 | 3d. Date of deliver | <u> </u> |
| Box 687 The death certification is the attending properties as the | Physician/ | 23b. Was decedent pregnant in the past 12 months? 1 Live birth 4 Pregnant at | time of death | _ = | er (Specify) | Ectopic | pregnancy | | Month I | Day Year |
| Box e death the atto | hysi | 1 Yes 2 No 9 Unknown g Unknown | | | | | | | | |
| Division of Vital Records, P.O. Box 68760, 4 Hospital or Attending Physician: The law requires that the death certificate be executed by hours after death. Funeral Director: After this certificate has been signed by the attending physician and lely filled in by the funeral director, page 2 should be detached for use as the burial - transi | by P | Part II. Other significant conditions contributing to death | t but not resul | lting in the un | derlying cause | given in Pa | | | | the cause of death? |
| rds, requires seen sig | eted | | | | | | | as an | 24b. Were au | itopsy findings available |
| ecor ne law i te has t ge 2 sh | Completed | | | | | | | utopsy erformed? | | completion of cause of |
| tal Rection: The certificate ector, page | Be C | 25. Was case referred to medical | | | 26.Pla | | (Check only one) | 2 2 | 10 10 11 | 2 140 |
| Division of Vital Records, saler details and Attending Physician: The law require that death. After this certificate has been sited in by the funeral director, page 2 should be | ျ | 1 163 2 140 | ent 2 FER | | | Other ₄ | Nursing Home 5 | | ence 6 Othe | r: |
| on of nding Pl th. :: After | ion: | 27. Manner of Death 1 X Natural 5 Pending 28a. Date of Inju (Month, Day,Y | ry 28 ear) | 3b. Time of Inj | | jury at Work | | be now in | jury occurred | |
| Divisior Hospital or Attend 24 hours after death Funeral Director: | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of In | jury - At home | e, farm, street | factory, office | building, et | | | and Number or Ru | ural Route Number, City |
| Divi Hospital or 24 hours afte Funeral Dir | Cert | 4 Homicide determined (Specify) | | | | | or low | n, State) | | |
| To the Ho within 24 h To the Fur completely | Medical | 29a. Certifier 1 Certifying Physician: To the best of my one) 2 Medical Examiner: On the basis of examiner: | | | | | | | | |
| To the within 2 To the complet | Med | 29b. Signature and title of certifier | | | | nse number | | | Date signed (Mo | |
| On | | anote. | | | 0.0 | M.E. | | Fel | bruary 5, 2008 | 3 |
| ogu | | 30. Name and address of person who completed cause of d | • | | root Delitie | 14D | 21201 | | | |
| 9 | ate | Ana Rubio MD. Assistant Medical Exam 31. Date filed (Month, Par Year) 1 2008 32. Registra | | i reiin St | reet, Baltim | iore, MD | | | | |
| - Maria | | FEBILI 2008 Ma. | | Le 1 | 4.0 | | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State Registrar Amend | 23a, p state of Maryland / Department of Health and Mental Hygiene | 1- State Registrar Amend | 1 tems | 25,27,28a-f | per math Cate of Death | Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year 5:10 P^M Moise Abecassis 2, 2008 February /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery General Hospital Olney Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F Director 218-06-5605 90 1, 1918 Morocco Jan. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 kd Yes 2 □ No Director MD Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3339 Beaver Wood Lane 20906 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: "natural", or Maryland 21215-0036 1 ☐ Yes 2 K No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clothing Designer Retail permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Yosef Abecassis <u>Simy Levy</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Abecassis - Son 11308 Broad Green Drive Potomac, MD 20854 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery: 4 Donation 5 Other (Specify) 2/3/2008 Adelphi, Maryland 22. Name and Address of Facility 21. Signature Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** neumonic /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ Left Hip fracture 1 Yes 2 No 3 Probably 4 Donknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy page perforn certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 No 2 No 1 Inpatient ٩ 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Medical Certification: 28c. Injury at Work? 5 Pending investigation Injury Subject fell out of bed 01/07/2008 Unknown M 1 ☐ Yes 2 χ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) **Home** 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3339 Beaver Wood Lane, Silver Spring, Md determined 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) Philip Drive 18/01 Prince 31. Date filed (Month, Day, Year) FEB 0 7 egistrar's Signature State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1,2008 Month **Physician** Troy February Cecil 7:13p Bartlett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurel Regional Hospital Laurel Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Min. 1X M 2 □ F Hours Yrs. 63 Director 579-38-3493 11/20/1944 West Virginia Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits ns 23a or 28a-f show must be notified at 1 Yes 2 No Directo Maryland Prince Georges Laurel with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13714 Engleman Drive 20708 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Examiner Armed Foldes:
1 ⊠ Yes 2 □ No
If Yes, Give
Year or Dates: 64-65 1 ☐ Never Married 2 ☑ Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No þ Specify Black 3 Widowed 4 Divorced "natural" the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Arlington County Elementary/Secondary (0-12) College (1-4or 5+) 12 Counselor Virginia 7 Is marked other traumatic event, tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Troy Bartlett Ethel Levystein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Joan Bartlett/ Wife 13714 Engleman Dr. Laurel, Maryland 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of I
Important: If its
any injury or o
once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 2/13/08 Cheltenham, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Adams Funeral Home PA 191 20605 Aquasco Rd. Aquasco, Maryland20608 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or field failure. List only one cause on each line.

Immediate Calise (Final disease or condition resulting in death)

a. Myocardial Infarction Approximate Interval Between Onset and Death **Physician** hours /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease 5 years Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a nonsequence or) Examine law requires that the death certificate be executed Chronic Renal Failure 5 years burial-trai Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical Diabetes 10 years the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death Year 5 Other (specify) s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 Hyperlipidemia 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed <u>Ventricular</u> Tachycardia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has to autopsy performed? Yes 2X No certificate Congestive Heart Failure funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) and tille of certifie 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) ddress of person wh mpleted cause of death (Item 23a) (Type, Print) LBA BALTIMOVE ALL RGOLIS, MD 13952 31. Date filed (Month, Day, Year) 32. Bedistrar's Signature State FEB 08

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [05488 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** 11:37 PM 2008 Mary Ruth Barnes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Westminister Carrol1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 TF Months Yrs. Director 219-16-8583 83 Tennessee Feb. 25,1924 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location Item 27 is marked other then "naturel", or Itema 23a or 28a-f show other traumatic event. Its Madical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Frederick Ijamsville the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 4925 Mussetter Road Completed by Funeral 21754 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 □ Never Married 2 □ Married 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Electronics Assembler Singer/Link Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H ie marked ot Be ပ James Thomas Noe Nannie McFarland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Depertment of Health a Important: If Item 27 is eny injury or other tra once. Ellen Krakau/ Daughter 4925 Mussetter Road, Ijamsville, Maryland 2<u>1754</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 2/14/2008 4 ☐ Donation 5 ☐ Other (Specify) Emanuel Methodist Cemetery Laurel, Maryland 21. Signature of Fundral Service Licensee 22. Name and Address of Facility
Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or com shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one/cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Se 105 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ed by the attending physicien detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 cete has been signated by page 2 should b 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy 1 Yes 2 No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 ER/Outpatient 3 DOA After this 27. Manuar of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number mi DOC66184 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eld Almutairy, MD 200 Memorial Avenue, Westminster, Maryland 21157 31. Date filed (Month, Day, Year) FEB 12 State 2008

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| | | Please Type or Print State of Mar | ryland / Depa | artment of Health and I | | | | | | |
|---|-------------------|--|------------------------------------|--|---|--|--|--|--|--|
| | | Registrar | Ce | rtificate of Death | Reg. | | | | | |
| Physic /Medi | | 1. Decedent's Name (First, Middle, Last) Alvin Henry Bird | | | February | Day Year 14, 2008 6:30 P ^M | | | | |
| Exami | ner | 4a. Facility Name (If not institution, give street and number) | | 4b. City, Town, or Location of Death | h | 4c. County of Death | | | | |
| | | Garrett County Memorial Ho 5. Social Security Number 6. Sex 7. Age | spital (In yrs. last birthday) | Oakland If Under 1 Year If Under 24 Hrs. | 8. Date of Birth | Garrett 9. Birthplace (State or Foreign | | | | |
| Funeral Director | | 213-28-9542 1 X 2□ F 76 | Ven | Months Days Hours Min. | Feb. 20 1 | ear) Country) | | | | |
| | | Usual Residence of Decedent | | | TCD: 20 1 | 1931 Tennsylvania | | | | |
| rylan how | | 10a. State 10b. County | 10c. City, Town or Lo | ocation | | 10d. Inside City Limits | | | | |
| e Ma Ba-f s | cto | MD Garrett | Deer Par | k | | 1 □Yes 2√ No | | | | |
| be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | Director | 10e. Street and Number | | 10f. Zip Code | 10g. | Citizen of What Country? | | | | |
| s 23a | srai | 53 Bird Avenue | res in LLC 42 | 21550 | | nited States | | | | |
| item item | Funeral | 11. Manital Status 12. Was Decedent Ex Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ Married | 13. | Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer | to Rican, etc.) | Black, White, etc. | | | | |
| urs af al'; or xam | by | If Yes, Give 3 Widowed 4 Divorced Year or Dates: | | 1 ☐ Yes 2 🛣 No Specify: | | Specify: White | | | | |
| 2 hou | | 15. Decedent's Education | 16a. Dece | dent's Usual Occupation | 161 | b. Kind of Business/Industry | | | | |
| thin 7 e. an "r | Completed | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+ | life. | kind of work done during most of wor DO NOT use retired) | King | 1 | | | | |
| ed wil ygien er th t, the | ő | 2 | mac | hinist | | union | | | | |
| be fill d oth even | Be | 17. Father's Name (First, Middle, Last) | | | me (First, Middle, Mai | | | | | |
| 2 should and Mer is marke | မ | Henry Lester Bird | 100 10 70 | Catheri ng Address (Street and Number or Ri | ne Marie V | | | | | |
| nd 2 should be filed within the and Mental Hygiene. 27 Is marked other than r traumatic event, the Me | | 19a. Informant's Name/Relationship (Type. Print) | | , | · | · · · · · / | | | | |
| s 1 and 2 f Health Item 27 | | Rodney H. Bird, Son 20a. Method of Disposition | 20b. Place of Dispo | ird Ave., Deer Pa | | c. Location - City or Town, State | | | | |
| Pages nent of int: If It | | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) | | matory or other place) | 5 / O 0 P c | Altimore MD | | | | |
| permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once. | | 21. Signature of Funeral Service Licensee | | 2. Name and Address of Facility | | altimore, MD | | | | |
| permit. Departm Importa any inju | | Katherine Shreiter | | David A. Burdoc 21 N. Second St | k Funeral | Home, P.A. | | | | |
| 1 | | 23a. Part1. Enter the disease, or complications tha c used to shock, or heart failure. List only one cause on ach line | he death. Do not en | ter the mode of dying, such as cardia | c or respiratory arrest | Approximate Interval Between | | | | |
| Physician /Medical Examiner hysician and physician | ical Examiner | Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Last ERIO XEROTIC GROW ANY UKCURY Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | |
| The law requires that the death certificate I has been signed by the attending physicage 2 should be detached for use as the b | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown | Fetal death 3 | □Ectopic pregnancy □ Other (specify) | | 23d. Date of delivery Month Day Year | | | | |
| w requires that s been signed b should be dete | by | Part II. Other significant conditions contributing to death but Renal Failure | 23e. Did tobac | obacco use contribute to the cause of death? Yes 2 | | | | | | |
| | Completed | Type II Drabetes | mel | litu | 24a. Was an autopsy performe | 24b. Were autopsy findings available prior to completion of cause of death? No 1 \(\text{Yes} \) 2 \(\text{No} \) | | | | |
| ician Sertific ector, | Be | 25. Was case referred to medical examiner? | | Othor: | ath (Check only one) | | | | | |
| Phys this (| 2 | 1 ☐ Yes 2 No Hospital: 1 Inpatien 27. Manner of Death 28a. Date of Injury | | | dome 5 ☐ Residence | e 6 Other (Specify) | | | | |
| ding h. After fune | tion | i Natural 5 Pending (Month, Day 2 Accident investigation | | of 28c. Injury at Work? M 1 □ Yes 2 □ No | Zod. Describe now | injury occurred | | | | |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | Certification: | ±□ nooldoni | y - At home, farm, st (Specify) | reet, factory, office | et and Number or Rural Route Number, State) | | | | | |
| he Hospit in 24 hours he Funera pletely fille | Medical C | 29a. Certifier (Check only one) 1 SertifyIng Physician: To the best of 2 Medical Examiner: On the basis of and manner state | examination and/or in | th occurred at the time, date and plac nvestigation, in my opinion, death occ | e, and due to the caus urred at the time, date | se(s) and manner as stated. e and place, and due to the cause(s) | | | | |
| To t within To t | 4 | 29b. Signature and title of certifier | 0 | 29c. License number | 4 29d | Date signed (Month, Day, Year) | | | | |
| | 5 | 30. Name and address of person who completed cause of dea Paul Danie Muer 31. Date filed (Month, Day, Year) 32. Registrar | De 69 | WC/FREES | Dr Oak | Jaml MD 21550 | | | | |
| St Regist | ate trar | FEB 1 5 2008 | Kinner A | Anna | | | | | | |

| | | | 1 - For State Registrar | | State of | of Mar | yland / De <i>C</i> | partmer ertifica | nt of H | lealth a Death | and M | | giene2 | 008 | 0549 |
|----------------------------|---|----------------|---|-----------------------------|------------------------------------|-----------------------------|--------------------------------------|------------------------------|---------------------------|----------------------------|------------------------|---|--------------------------------|------------------------------|--|
| | Dhysisi | - | Decedent's Name (First | | | | | | | | | 2. Date of Death Month Day Year 3. Time of Death | | | |
| | Physici /Medio | | Betty Jane | | | | | | | | | February 6, 2008 5:20 A | | | |
| 7 | Examir | er | 4a. Facility Name (If not in Goodwill Me | | | | | | | r Location o | of Death | | | nty of Death rrett | |
| | Funeral Director | | 5. Social Security Number 218–16–3608 | 6. S | | | In yrs. last birthd | y) If Unde Months | r 1 Year Days | If Under Hours | 24 Hrs. Min. | 8. Date of Birth (Month, Day Oct 21, | , Year) 1921 | 9. Births Cour Mary | place (State or Foreign ntry) land |
| | P . | | Usual Residence of Dece | | | 1. | Oc. City, Town or | Location | | | | | | | 10d. Inside City Limits |
| | ehov | ā | | arrett | | ' | McHenry | | | | | | | | 1 ☐ Yes 2 ☑ No |
| | death with the Maryland ome 23a or 28a-f show or mat be notified at | Director | 10e. Street and Number | TLLECC | | | TICHCHE | | Code | | | | 10g. Citizen | of What Cou | ntry? |
| | th with | iQ je | 25542 Garre | ett Hi | ghway | | | 2 | L5 4 1 | | | | USA | | |
| | iteme | Funeral | 11. Marital Status | | 12. Was Dec | edent Eve | er in U.S. 1 | 3. Was Dece | dent of H | ispanic Or in, Mexical | igin? (Sp | ecify Yes or No- Rican, etc.) | | Race - Ameni | |
| 36 | g 9 2 | by Fu | 1 Never Married 2 3 X Widowed 4 D | | 1 ☐ Yes If Yes, Gi Year or D | 2 No | | 1 ☐ Yes | | Specify: | | | Spe | city: whi | te |
| 8 | 2 should be filed within 72 hours after and Menial Hyglene. Is marked other than "naturel; or its eumatic event, the Madical Examine | | | ecedent's Ed | | Dates: | 16a. De | cedent's Usu | al Occup | ation | | | 16b. Kind o | Business/In | dustry |
| 215 | - 25 | plet | | highest gra | de completed) College (| | (G | ve kind of we . DO NOT L | ork done d ise retired | during mos d) | it of work | ing | | | , |
| 21 | giene giene er tha | Completed | Elonionary, 5000mary | | 2 yrs | | Hor | emake | : , | | | | Own H | | |
| B | be file tal Hy d oth | Be | 17. Father's Name (First, I | | | | | | | | | e (First, Middle, | | ame) | |
| <u>Ş</u> | d Men marke | 2 | Asa E. Glot | | Type Print | | 10h M | ilina Addros | Ctroot | | | (Glotfe | | um State Zir | n Codel |
| Maryland 21215-0036 | d 2 sl Ith and 27 ie r treur | | S. Edward H | | | ì | | | | | | , McHenr | | 2154 | |
| 5 | s 1 an f Heel item 2 | | 20a. Method of Disposition | | - | | 20b. Place of Di | | me of | 1 | | Date | | on - City or To | own, State |
| E O | Page nent o int: if | | 1 🔀 Burial 2 □ Crer 4 □ Donation 5 □ C | | | State | Thayerv | • | | | 9, | 2008 | Oaklar | nd, MD | |
| Baltimore, | permit. Pages 1 and 2 should be filed within Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than eny injury or other freumatic event, the Magnee. | | 21. Signature of Funeral Service Ligensee Newman Funeral Homes, P.A., P.O. 179 Miller St., Grantsville, MD | | | | | | | | | | | | |
| 8760, | certificate be executed | dicai Examiner | 23a. Part1. Enter the dises shock, or heart failth. Immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | e. List only | a | oach line. | consequence of): | | | | | | | | Interval Between Onser and Death |
| .O. Box 6 | death certif e attending id for use a | Physician/Med | IF FEMALE: 23b. Was decedent pregn in the past 12 minth 1 ☐ Yes 2 ☑ No 9 ☐ Unknown | | | birth 2 (nant at tim | | 3 □Ectopic p 5 □ Other (s | | | | | 1 | Date of delive | ery Day Year |
| ٥. | law requires that the d as been signed by the 2 should be detached | by Ph | Part II. Other significant of | onditions o | ontributing to d | leath but r | not resulting in the | underlying | cause giv | en in Part I | | 23e. Did to | bacco use c | ontribute to t | he cause of death? |
| ğ | w require been sig should b | ed b | Old | Cerep | nal | str | oke | | | | | 1 🗆 Y | es 200 No | 3 ☐ Prol | bably 4 Unknown |
| မင္မ | has be | Completed | Dem | entia | | | | | | | | 24a. Was a autop | an 24 | b. Were auto | opsy findings available empletion of cause of |
| R | Page 1 | Con | | | | | | | | | | perfor | med? 2 ☑ No | death? | 2□ No |
| Vita | Physician: Th this certificate ral director, pag | Be | 25. Was case referred to examiner? | medical | Hospital: | | | | Oth | on / | | h (Check only or | ne) | | |
| 5 | Phys rthis raldi | 5 | 1 ☐ Yes 2 ☑ No 27. Manner of Death | | 1 [| Inpatient of Injury | 2 ER/Outpa | | JA | 4 15 NI | ursing Ho | me 5 Resid | | Other (Special curred | fy) |
| on | Attending F r death. ector: After by the funer | ation | | Pending investigation | 28a. Date (Mor | nth, Day Y | 'ear) Injui | / м | 28c. Injun Work | k? Yes 2 ☐ | | | | | |
| Division of Vital Records, | or Attendia ifter death. Director: A in by the fu | Certification; | | Could not be determined | 286. Place | e of Injury ling, etc. (| - At home, farm, Specify) | street, factor | y, office | | | 28f. Location (S City or Tow | | imber or Rur | al Route Number, |
| | Hospital 4 hours a Funerel I ely filled | edicai Ce | 29a. Certifier 1 1 M C (Check only one) | ertifying Ph edical Exan | iner: On the b | e best of roasis of ex | my knowledge, di kamination and/o | ath occurred investigation | at the tin | ne, date ar pinion, dea | nd place, ath occur | and due to the cred at the time, c | cause(s) and date and place | manner as s ce, and due t | stated. o the cause(s) |
| | To the within 2 To the complet | Me | 29b. Signature and title of | certifier | | 1 | | | | e number | 21 | | | ned (Month, | |
| , | | | 7.(| tha | ngn | 1 0 | | | У | 216 | 5 20 | > | tekn | eary | 6 2002 |
| | | 2 | 30. Name and address of SATURNIA | | | se of deal | in (Item 23a) (Ty) | e, Print) | 24 | FRO | 120 | ing r | lary Co | and | 21532 |
| | Sta | te | 31. Date filed (Month, Day | | 32. | legistrar's | Signature | 1. 1 | 4 | 4.20 | | | | | |

Registrar
DHMH 17 Rev 1/2001

State

Melnick, MD

2008

FEB 08

John A

31. Date filed (Month, Day, Year)

Gaithersburg, MD 20879

911 Russell Avenue

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| | | | 1 - For State Registrar | State of Ma | ai ytai io | | tificate of | | | 10116 2 () | 08 05492 |
|----------------|--|----------------|--|---|--|------------------------------|-------------------------------------|---|---|--|---|
| | Physici | 0.10 | 1. Decedent's Name (First, Middle, Las | st) | | | | | 2. Date of Deat Month | | 3. Time of Death |
| 4 | /Medic | | Crawford L. Barr | | | | | January | 28, 200 | 8 12:15 PM ^M | |
| 1 | Examir | er | 4a. Facility Name (If not institution, give | | 4b. City, Town, or Location of Death 4c. County of Death | | | | | | |
| | | | 909 Malcolm Driv 5. Social Security Number 6. S | st hirthday) | Silver If Under 1 Year | Spring If Under 24 Hrs. | 8. Date of Birth | Montg | Omery Birthplace (State or Foreign | | |
| | Funeral Director | 10 M 2DE | | | | | Months Days | Hours Min. | OEC. 20, | Year) 1941 T | Country) ENNESSEE |
| | /land | | 10a. State 10b. County | | 10c. City, | Town or Lo | cation | | | | 10d. Inside City Limits |
| | Man | į | MD. MONTGON | 1ERY | | | SILVER | RSPRING | | | 1 X Yes 2 No |
| | or 28 | Director | 10e. Street and Number | | | | 10f. Zip Code | | 1 | 0g. Citizen of Wh | al Country? |
| | 23a | al | 909 MALCOLM DE | . | | | 2 | 20901 | | U.S. | Α. |
| | r dag | Funeral | 11. Marital Status | 12. Was Decedent I Armed Forces? | Ever in U.S | . 13. | Was Decedent of I | lispanic Origin? (S an, Mexican, Puerl | pecify Yes or No- o Rican, etc.) | | American Indian, White, etc. |
| 21215-0036 | 2 should be filed within 72 hours after daath with the Maryland and Mental Hygiene. is marked other then "netural", or iteme 23s or 28s-f show eumatic event, the Medical Examinational be redified at | þ | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 1 ∰Yes 2 ☐ N If Yes, Give Year or Dates: 1 | | AM | 1 □ Yes 2 🛣 No | Specify: | | Specify: | BLACK |
| 5 | 72 h | etec | 15. Decedent's Ed (Specify only highest gra | lucation de completed) | | 16a. Deced | ient's Usual Dccup | pation during most of word) | king | 16b. Kind of Busin | ness/Industry |
| 12 | vithin | Completed | Elementary/Secondary (0-12) | College (1-4or 5 | | | | | 1 | VALTER R | |
| | filed v Hygie other t | | 12 17. Father's Name (First, Middle, Last) | | | SUPERV | ISOR HEA | LTH SYS. | SPEC. 1 | | |
| Maryland | d be | o Be | | . BARRON | CD | | | | RSKIE | REDD | |
| <u> </u> | should ind Men marke umatic | ဥ | 19a. Informant's Name/Relationship (| | 91. | 19b. Mailir | a Address (Street | and Number or Ru | | | ate. Zip Code) |
| | 글 52 글 달 | | OLIVINE M. BARRO | N/WIFE | | | | | | | , MD. 20904 |
| re, | of Hea of Hea fitam | | 20a. Method of Disposition | - | 20b. Pla | ce of Dispo | sition (Name of natory or other pla | | | 20c. Location - Ci | |
| E | Pages nent of ant: If its | | 1 ☐ Burial 2 【A Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify | | | , . | CREMATOR | 1 | 2008 | RIVERDA | LE, MD. |
| Baltimore, | permit. Pages Department of important: If it eny injury or o | | 21. Signature of Funeral Service Licen | 500 | | 22 | Name and Addre | SS of Facility FUNERAL | | | |
| _ | 207 | | MINI Cha | mberge | M000 | 091 5 | 801 CLEA | ELAND AV | E., RIVE | RDALE, M | D. 20737 |
| П | | | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only | olications That caused one cause on each lin | the death. | Do not ent | er the mode of dyli | ng, such as cardiad | or respiratory arre | est, | Approximate Interval Between |
| | Physician | | Immediate Cause (Final disease or condition resulting in death) | a. HYPHI | fen | sive | carl | DVASL | Viso | 999 | Onset and Death |
| | /Medical Examiner | | Tosting in doubly | Due to (or as | a conseque | ence of): | | | | | |
| | ţ | ē | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b. Due to (or as a | a conseque | ence of): | | | | | |
| | uted d ansit | Examin | cause. Enter Underlying Cause (Disease or injury that initiated events | | | | | | | | |
| oʻ | ifficate be executed g physicien and as the burial-transit | Exa | resulting in death) Last | Due to (or as | a conseque | ence of): | | | | | |
| 68760, | ate be hysici | edical | | d | | | | | | | |
| | | | IF FEMALE: | | | | | | | | |
| Box | eath certi attending I for use a | lan/ | 23b. Was decedent pregnant in the past 12 months? | 23c. If yes, outcome 1☐Live birth | 2 Fetal d | leath 3 | Ectopic pregnanc | 1 | | 23d. Date of | |
| o. | The law requires that the death ce site has been signed by the attendi bage 2 should be detached for use | Physician/N | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 4□Pregnant at 9□Unknown | time of dea | ith 5 | Other (specify) _ | | | | |
| ج. | that hed by deta | y Ph | Part II. Other significant conditions of | ontributing to death bu | ıl nol result | ting in the ur | nderlying cause giv | en in Part I. | 23e. Did Iob | acco use contribu | ute to the cause of death? |
| Vital Records, | w requires been sign should be | ed by | | | | | | | 1 □ Ye | s 2 No 3 | ☐ Probably 4 Unknown |
| O O | s been 2 shoul | Completed | | | | | | | 24a. Was a | 24b. We | ire autopsy findings available |
| Ä | The lav | mo | | | | | | | autops perform 1 Yes 2 | ned? dea | or to completion of cause of ath?] Yes 2□ No |
| | | BeC | 25. Was case referred to medical examiner? | | | | | 26. Place of Dea | th (Check only on | | 7100 2010 |
| - | d is | 2 | 1 Yes 2 □ No | Hospital: 1 ☐ Inpatie | nt 2□El | R/Outpatien | t 3□ DOA Ott | 4 Unursing n | ome 5 Reside | nce 6 Other | (Specify) |
| ב | ing P | Ü | 27. Manner of Death 1 Natural 5 □ Pending | 28a. Date of Injur (Month, Day | Year) 2 | 8b. Time of Injury | 28c. Injui | | 28d. Describe ho | w injury occurred | |
| Sic | Attending r death. ector: After by the fune | cat | 2 Accident investigation 3 Suicide 6 Could not be | | .n. Athan | | | Yes 2 □No | ORE Leasting (Ca | | - 2 - 12 |
| DIVISION | or A aftar i Direct | Certification; | 4 Homicide determined | building, etc | . (Specify) | ie, iaim, sm | set, lactory, office | | City or Town | , State) | or Rural Route Number, |
| | To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral | | (Check only 21/2 Medical Exam | ysician: To the best of liner: On the basis of | examinatio | ledge death on and/or inv | occurred at the til | ne date and place pinion, death occu | and due to the es rred at the time, da | tusa(s) and mann ate and place, and | of as stated d due to the cause(s) |
| | o the rithin 2 o the omplet | Medicai | 29b. Signature and title of certifier | and memner sta | ted. | | 29c. Licens | | | | Month, Day, Year) |
| , | + ≥ ∓ 8 | | 3 3 cm 20 5 | | no 0 | | Do | 0428 | 0 0 | e 4 | 2008 |
| | 11. | | 30. Name and address of person who call a RECK | completed cause of de | eath (Item 2 | 23а) (Туре, | 91101 91101 | medic | of Pai | X D 6 | 23 |
| | Sta | te | 31. Date filed (Month, Day, Year) | 32 Registra | | re | 7111 | Sprim | 1 0170 | ~ 1 - | |
| | Registr | | FEB 0 8 200 | 8 Aller | , St. | 1 | w | | | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2. Date of Death Month Day February 16, 2008 0820 hrs 4c. County of Death 4b. City, Town, or Location of Death Talbot 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) Days Hours OCT 10,1961 MICHIGAN 10d. Inside City Limits 1 Yes 2 X No 10g. Citizen of What Country 21601 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 X No specify: Specify: WHITE 16b Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) DOCTORS OFFICE MEDICAL ASSISTANT 18.Mother's Name (First, Middle, Maiden Surname) GENEVA MASTAW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29195 CORBIN PARKWAY, EASTON, MD 21601 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date CHESAPEAKE CREMATION CTR 2/22/2008 STEVENSVILLE, MD 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL 200 S. HARRISON ST. FASTON, MD 2160

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart HOME PA Approximate Interval Between Onset and Death Seizures Due to Traumatic Brain Injuries $\overline{\mathbb{X}}$ amended 23a, 27, 28a-f per ME g877 03/17/08 amh 23d. Date of delivery Year 3 Ectopic pregnancy Day 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 ✔ Unknown Completed ficate has been si, page 2 should b 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy his certificate has be director, page 2 sh death? performed? ✓ Yes 2 No 1 🗸 Yes No 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Other 4 examiner? Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 this 1 🗸 Yes ဥ No After the 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of Injury 28c. Injury at Work? Certification: 1 Natural Yes 2 X No Pending neral Director: y filled in by the f October 22,1980 Unknown <u>Coupant in motor vehicle accident</u> 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Milford Road and Rattalee 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide determined (Specify)Roadway 4 Homicide ake Road. 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. February 17, 2008 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001 **OCME 2006**

Registra

within 24 hours after death

Division of Vital

Brown.

| | | | Pleas | e Type or Pri | nt in E | Black I | ndelible Ink | . Ensure A | II Copies | Are Leg | ible. | |
|--|------------------|---|-------------------------------------|--|-------------|------------------------------|--|-------------------------------|--------------------------------|-----------------|------------------|--|
| | | For | | State of Ma | arylan | - | partment of F | | lental Hy | giene | 000 | OFI OL |
| | | 1 - State Registrar Certificate of Death | | | | | | | Reg. No. 2008 05494 | | | |
| Physic | ian | 1. Decedent's Name (First, Middle, Last) | | | | | | 2. | | | Year | 3. Time of Death |
| /Medi | cal | 4- 5 | | Audrey Adel | ine l | Brown | T | | Februar | - | 2008 | 0648 A ^M |
| Exami | ner | | | give street and number) | | | | r Location of Death | | | ty of Death | |
| Funeral | _ | 5. Social Security N | il Stre | | e (In yrs. | last birthda | y) If Under 1 Year | eake City If Under 24 Hrs. | 8. Date of Birt | h | cil 9. Birthp | place (State or Foreign |
| Director | | 212-50-6 | 536 | 1□M 2MF 58 | 3 | Yrs. | Months Days | Hours Min. | (Month, Day April 1 | | Coui | vland |
| pu » | | Usual Residence of 10a. State | Decedent 10b, County | | | v. Town or | Lastina | | 1.0 | | | |
| laryla shov ed at | 5 | | , | | | , | | | | | | 10d. Inside City Limits 1 1 Yes 2 ☐ No |
| the N 28a-f | Director | Maryland 10e. Street and Nur | Cecil | | CI | nesap | eake City | | | 10g. Citizen o | f What Cou | |
| filed within 72 hours after death with the Maryland Hygiene. ther than "natural"; or items 23a or 28a-f show ent, the Medical Examiner must be notified at | | | il Stre | et | | | 21915 | ; | | | ted S | |
| ms 2 | Funeral | 11. Marital Status | | 12. Was Decedent | Ever in U. | S. 13 | 3. Was Decedent of H | | ecify Yes or No | | ace - Americ | can Indian, |
| after or ite | | 1 🗌 Never Marri | 44 | Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give X | No | | 1 ☐ Yes 2 👿 No | Specify: | Hican, etc.) | Spec | ack, White, | etc. |
| nours ural"; il Exa | d by | 3 ☐ Widowed | | Year or Dates: | | | 187-18-19-19-19-19-19-19-19-19-19-19-19-19-19- | | | | Who | |
| "nati | Completed | (Spec | 15. Decedent's cify only highest | Education grade completed) | Ţ, | 16a. Dec | cedent's Usual Occup we kind of work done . DO NOT use retired | oation during most of work | king | 16b. Kind of | | oard of |
| withill lene. than the M | ᇤ | Elementary/Seco | ndary (0-12) | College (1-4or 5 | 5+) | | lministrat | | | | nty bo cation | |
| Hygi Hygi other ent, t | Be C | 17. Father's Name | (First, Middle, La | | | 110 | 111111111111111111111111111111111111111 | 18. Mother's Nam | | | | 1 |
| Ald be Aenta rked tic ev | To B | Joseph | Latimer | Lynch | | | | Doroth | y Crawf | ord | | |
| and N | r | 19a. Informant's Na | ame/Relationship | (Type. Print) | | 19b. Ma | iling Address (Street | and Number or Rui | ral Route Numbe | er, City or Tow | n, State, Zip | Code) |
| and 2 ealth n 27 i | | | | e/Husband | | | Cecil Str | | | | | |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | | 20a. Method of Disp 1 🛛 Burial 2 | | ☐Removal from State | 20b. P | Place of Dis cemetery, ci | position (Name of rematory or other plac | ^{ce)} Febru | Date 1arv | 20c. Location | ı - City or To | own, State |
| tmen tant: | | 4 Donation | 5 Other (Spe | cify) | I | Bethe: | l Cemetery | 20 2 | 2008 L | Chesa | peake | City, MD |
| permi Depar Impor any ir | | 21. Signature of Fu | ineral Service Li | censee | | Ë | 22. Name and Addre licks Home 03 W. Sto | for Fune | rals,_P | . A . | | |
| | | 23a Part1 Enter ti | he disease or or | emplications that caused | the death | h Donote | .03 W. Sto | ckton Str | eet, E1 | kton. N | 1D 219 | 021 Approximate |
| Dhamisian | ш | shock, or hea Immediate Cause (| rt failure. List or | lly one cause on each li | ne. | _ (| 7 | igi oddii do odraido | or respiratory as | 7000, | | Interval Between Onset and Death |
| Physician /Medical | | disease or condition resulting in death) | n | a. Due to (or as | a consequ | unce of): | ance | ^ | | | | |
| Examiner | | | | 240 10 (0) 40 | a 00,100q1 | unito 01). | | | | | | |
| | ē | Sequentially list con if any, leading to im cause. Enter Unde | nditions, nmediate | Due to (or as | a consequ | uence of): | | | | | | |
| executed in and ial-transi | Examiner | Cause (Disease or that initiated events | injury | с | | | | | | | | |
| be executed cian and burial-transit | Ä | resulting in death) L | Last | Due to (or as | a consequ | uence of): | | | | | | |
| ficate by physic s the b | | | | d | | | | | | | | |
| leath certific attending p for use as t | Physician/Medica | IF FEMALE: | | 23c. If yes, outcome | pf pregna | апсу | | | | 224 [| ate of deliv | one |
| leath atter | ciar | 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ | months? | 1 □Live birth 4 □Pregnant at | 2 Feta | I death 3 | Ectopic pregnancy | / | | | nonth | Day Year |
| t the o | hys | 9 ☐ Unknown | | 9□Unknown | | | | | | | | |
| The law requires that the death certificate be ate has been signed by the attending physicia bage 2 should be detached for use as the bur | by P | Part II. Other signif | ficant condition | s contributing to death b | ut not resu | ulting in the | underlying cause giv | ren in Part I. | 23e. Did to | obacco use co | ntribute to t | he cause of death? |
| equire en sie | led | | | | | | | | 1197 | es 2□No | 3 ☐ Prol | pably 4 □Unknown |
| law r las be | Completed | - | | | | | | | 24a. Was autop | | . Were auto | ppsy findings available impletion of cause of |
| | Con | | | | | | | | perfo | rmed? 2√⊒No | death? 1 Yes | 2 NO |
| or Attending Physician: The law ifter death. Director: After this certificate has t in by the funeral director, page 2 s | Be | 25. Was case refer examiner? | | Hospital: | | | Oth | 26. Place of Deat | h (Check only o | (12 0) | | |
| Phys r this ral dir | <u>P</u> | 1 ☐ Yes 2 1 27. Manner o ≥ at | AT. | 1 ☐ Inpatie | | ER/Outpati 28b. Time | | 4 □ Nursing Ho | ome 5 Aesic 28d. Describe h | | | fy) |
| nding th. : Afte e fune | tion | 1 Namural 2 ☐ Accident | 5 Pending investigat | (Month, Da | y Year) | Injury | Wor | k? Yes 2 □ No | 200. 200011201 | ion injury occi | anou | |
| Atter r deal ector by the | iţica | 3 ☐ Suicide 4 ☐ Homicide | 6 ☐ Could not determine | d 28e. Place of inju | | | street, factory, office | | 28f. Location (S | Street and Nun | nber or Run | al Route Number, |
| salor safte al Dir | Certification: | 4 [] Horricae | | building, et | c. (Specii) | y) | | | City or Tou | n, State) | | |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, | edical | 29a. Certifier (Check only | 1 - Certifying | Physician: To the best aminer: On the basis o | of my kno | wledge, de | ath occurred at the ti | me, date and place, | and due to the | cause(s) and r | manner as s | stated. |
| the hin 24 | Medi | one) | | and manner sta | ated. | | | | | | | |
| vitl To | - | 29b. Signature and | title of certifier | | | | 29c. Licens | e number | 1110 | 29d. Date sigr | ied (Month, | Day, Year) |
| ٨ | | 20 No === === | 000 of | on completed as a second | ooth /lt- | V | MID Y | 14064 | 1471 | d | 17/0 | 0 0 |
| () | 1 | 39. Name and addr | | no completed cause of d | N/L | (1ype | (1)02+ | Hoshs | 79 | to | 300 F | THAN TUN |
| Sta | ate | 31. Date filed (Mon | | 32. Registr | ar's Signa | ture | 1 4 | 010900 | 1. 00 | | | 11411 |
| Regist | rar | | FEB 2 | 5 2008 | m | A. | grava) | | | | | |

law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, detached Hospital or Attending Physician: director After this funeral r death. 24 hours after death Funeral Director:

Baltimore, Maryland 21215-0036

Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Harry E. Barron, Jr. 3:50 PM FEBRUARY 16, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Saint Joseph Medical Center Baltimore Towson if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 20, 1942 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min Maryland 1 XM 2 □ F 215-42-5598 65 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 □Yes 2X No Baltimore Phoenix 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21131 U.S.A. 2323 Carroll Mill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married White 1 ☐ Yes 2 No 2 Specify: 3 Widowed 4 Divorced Year or Dates: "natural" Completed er than "natur , the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Public Water Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Lab Technician Utilities 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 Is marked or traumatic even Christine Thompson Harry E. Barron, Sr. ၉ Health and N tem 27 Is ma≀ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2323 Carroll Mill Rd., Phoenix,MD 21131 Joyce E. Barron, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State Feb. 21, ☐Burial 2 ☐Cremation 3 ☐Removal from State Timonium, MD 4 Donation 5 Other (Specify) 2008 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc 21. Signature of Funeral Service Licensee Which 24 Second St., New Freedom, PA 17349 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final **Physician** ISCHEMIC CARDIOMYOPATHY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions. it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to tor as a consequence of Examine sician and burial-trans Due to (or as a consequence of) physician s the burial Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 28a. Date of Injury (Month, Day Year) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Leading Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Leading Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) within 24 and manner stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D46350 DYUCZY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 TABASSI. M. D. OSLER DRIVE TOWSON MARYL <u>KHOSROW</u> 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2008 Registrar FEB 2 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 24a per land Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month **Physician** 8 2008 February Mary Gertrude Bednarczyk 1:30A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12350A Sherwood Forest Drive Frederick Mt. Airy 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🛛 F Yrs. **Director** 188-32-9658 93 Apr.27, 1914 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2X No r 28a-f sh notified Director Maryland Frederick Mt. Airy 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be 12350A Sherwood Forest Drive 21771 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home ulth and Mental Hvor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Hoholick Gertrude Barna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.8
Department of Health as Important: If item 27 is any Injury or other trau Box 283 <u> Olyphant, PA 18447</u> <u>Richard J. Bednarczyk/ son</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☒ Removal from State 2-13-2008 | Carbondale PA Mother of Sorrows 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service License Lar Ker 11802 Liberty Rd. Libertytown, MD 21762 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or a /a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: ed by the attendin detached for use 23c. If yes, outcome pf pregnancy
1□Live birth 2□ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 D No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause giver∫in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has 2 XNo 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 🗷 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of To the Hospital or Attending Pi within 24 hours after death, To the Funeral Director: After t completely filled in by the funers 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

opossmutoum Pike

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

any on

32.

, Mo

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 11 per inf g898 12-21-09 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2:55 A^M Julian W. Bazemore 2/15/2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Frederick Citizens Care and Rehab Ctr Frederick If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min **1X** M 2 □ F 220-14-0554 Director 93 7/13/1914 N.C. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show at 1 ☐ Yes 2 XNo be notified Director MID Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 "natural", or items 23a 10505 Putman Road 21788 USA Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 □ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21€ No Specify Specify: þ 3 ☐ Widowed 4 ĦDtvorced Year or Dates: 38 - 41 White Completed event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) filed within Hygiene. 11 Mechanic Air Craft Maint. Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ss 1 and 2 should be first Health and Mental Fitem 27 Is marked ot Kenneth Bazemore Carrie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8659 Indian Springs Rd Frederick MD 21702 Dee Klipp Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages 1 Department of F Important: If ite 1 ₭ Burial 2 Cremation 3 Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem Gdn 2/19/2008 Frederick, MD 22. Name and Address of Facility Keeney & Basford P.A. 21. Signature of Furieral Service Licensee F.H. any Ma M01176 106 East Church St. Frederick, MD 21701 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed and the burial-trai Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 □Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. the detached 9☐Unknown 9 Unknown þ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, 2 pe , 2 No 3 Probably 4 Honknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform certificate Division or Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Invursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 🗌 Yes ٩ 1 Inpatient 2 ER/Outpatient 3 🗆 DOA this funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After i Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: in by the 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined l or A 4 ☐ Homicide Hospital completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated e of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and 0 30. Name and address of person wb mpleted cause of death (Item 23a) (Type, 32. Registrar's Signature ed (Month, Day, Year State

DHMH 17 Rev 1/2001

Registrar

FER 25

08-01177 Valerie Ballentine

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| alene ballentine | 1 | State of Maryland / Department of For State State of Maryland / Department / Department / Departmen | | Reg. No. | |
|--|----------------|--|--|---|----------------------------|
| Physicia | _ | egistrar I. Decedent's Name (First, Middle,Last) | | 2. Date of Death | 3. Time of Death |
| ledical Examir | | Valarie J. Ballentine | | Month Day Year February 10, 2008 | 0614 hrs |
| J. 17 | | a. Facility Name (if not institution, give street and number) | 4b. City, Town, or Location of Death | 4c. County of Dea | |
| | | Prince George's Hospital | Cheverly | Prince Georg | |
| Funeral | | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) | If Under 1 Year If Under 24Hrs Months Days Hours Min | Fore | eign |
| Director | | 578-80-6998 1 M 2K F 49 Yr | | July 12,1958 ^c | Wash DC |
| any | - | Jsual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loca | tion | | 10d. Inside City Limits |
| <u>*</u> | | DC Washing | | | 1 XYes 2 No |
| Maryland 28a-f show d at once | 황 | 10e. Street and Number | 10f. Zip Code | 10g. Citizen of What Co | ountry? |
| th the Maryland 23a or 28a-f sho notified at once | Director | 3681 22nd St., SE | 20020 | United S | tates |
| 21215-0036 bid be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f she every, the Medical Examiner must be notified at once | | 11. Marital Status 12. Was Decedent Ever in U.S. 13. W | as Decedent of Hispanic Origin? (S | | encan Indian, Black, |
| or iten | Funeral | 1 Yes 2 K No | Yes, specify Cuban, Mexican, Puerto | o Rican, etc.) White, etc. | |
| after | by F | 3 Widowed 4 Divorced If Yes, Give Year 1 or Dates: | | Specify: B1 | |
| hours | ed | during r | ent's Usual Occupation (Give kind of most of working life. DO NOT use ret | | s/Industry |
| 36 in 72 Itan " | ompleted | Elementary/Secondary (0-12) College (1-4 or 5+) | None | None | |
| 5-0036 led within 72 hours a Hygiene. other than "natural the Medical Examin | 탉 | 12 17. Father's Name (First, Middle, Last) | | e (First, Middle, Maiden Surname) | |
| 21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", every, the Medical Examiner | Be C | James C. Ballentine | Hilda | G. Harris | |
| 21. hould bend Mer is mar | | 19a. Informant's Name/Relationship (Type, Print) 19b. Mailii | ng Address (Street and Number or 7 Tellico Plac | Rural Route Number, City or Town, Sta | ate, Zip Code) |
| e, MD I and 2 sho Health and Item 27 is | Į | James Ballentine/orother Cli | nton, Maryland | 1 20735 | as Tourn State |
| F & 7 F F | | 1 XBurial 2 Cremation 3 Removal from State crematory or c | other place) | | |
| Page ment tant | | 4 Donation 5 Other Specify: Washing | ton Nat. Cem. | 2/15/08 Suitl | and, Md. |
| Baltimore, permit. Pages lan Department of Hee Important: If Iter injury or other tr | | 21. Signature of Funeral Service Licensee 22. | Name and Address of Facility HC | odges & Edwards Ll Rd., Suitlan | F.H. |
| Physician | - 1 | 23a/ Part I. Enter the disease, or complications that caused the death. Do not enter | the mode of dying, such as cardiac | or respiratory arrest, shock, or heart | Approximate Interval |
| /Medical | | failure. List only one cause on each line. | | | Between Onset and Death |
| xaminer | - 1 | Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): | | | 1 |
| | . | Sequentially list conditions, b. | | | |
| | je | if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause | | | |
| . /= | Examiner | (Disease or injury that injurated events resulting in death) Last Due to (or as a consequence of): | | | |
| 60, Care be executed thysician and buysician and be burial - transit | | d | | | |
| OX 68760, leath certificate be exe e attending physician of for use as the burial | Medical | UNPENDED | | | |
| 376(ficate g phy: | | IF FEMALE: 23b. Was decedent pregnant in the 2 23c. If yes, outcome of pregnancy 1 Live birth 2 F | Fetal death 3 Ectopic pregr | 23d. Date of deliverancy Month | very Day Year |
| Box 687; death certific: | sician/ | past 12 months? Pregnant at time of death 5 | Other (Specify) | | |
| BO) e deatl the att | Phys | 1 Yes 2 No 9 V Unknown 9 Unknown | | | 4.4 |
| P.O. E es that the digned by the | by P | Part II. Other significant conditions contributing to death but not resulting in the | e underlying cause given in Part I. | 23e. Did tobacco use contribute 1 Yes 2 ✓ No 3 F | |
| S, P.C puires that | ed . | | | | autopsy findings available |
| cords, law requir has been s | Completed | | | | to completion of cause of |
| Rec The I | 悥 | | | 1 🗸 Yes 2 No 1 🗸 | Yes 2 No |
| tal Rec | Be | 25. Was case referred to medical examiner? Hospital: 1 Inspirate 2 FR/Outpatie | 26.Place of Death (Check ent 3 DOA Other | | ther: |
| f Vi Physi er this | ပို | 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of | | ing Home 5 Residence 6 O | uilei. |
| Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sted in by the funeral director, page 2 should the fine of the properties. | io :: | 1 Natural 5 Pending Feb 10, 2008 0529 hrs | 1 Yes 2 ✓ No | Subject stabbed | |
| ViSior or Attend of the death Director: | icat | 2 Accident Investigation 28e. Place of Injury - At home, farm, st | reet, factory, office building, etc. | 28f. Location (Street and Number or | |
| Div pital or cral Di filled in | Certification: | 3 Suicide 6 Could not be determined (Specify) Single Family | | or Town, State) 3681 22nd Street SE, Washingt | on, DC |
| Hos 74 h | | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ | curred at the time, date and place, ar | nd due to the cause(s) and manner as | stated. |
| To the within To the complet | Medical | one) 2 Medical Examiner:On the basis of examination and/or investigand manner stated. | | | |
| F × F ŏ | ž | 29b. Signature and title of certifier | 29c. License number | 29d. Date signed | |
| | | mel | O.C.M.E. | February 11, 2 | <u> </u> |
| 6 | | 30. Name and address of person who completed cause of death (Item 23a) | Street, Baltimore, MD 2120 | 01 | |
| 5 | | | Sueet, Baltimore, IVID 2120 | | |
| St Regis | tate trar | 31. Date filed (Month, Day, Year) FFR 2 5 2008 32. Registrar's Signature | BAR | | |

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State of Maryland / Department of Health and Mental Hygiene?

| A generalized and the second place of the passes of Name of American State (Annual Park Park Park Park Park Park Park Park | | | | Calconing | ertificate of Death | Reg. No. | .000 00477 |
|--|------------|--------------------------------------|----------|--|--|---|---|
| ELNORA ALBERTA BROWN FERRUARY 13 2008 5:25 am Sunbridge Nursing Home Sunbrid | | | | Decedent's Name (First, Middle, Last) | | | |
| Sunbridge Nursing Home Function Sunbridge Nursing Home Function Sunbridge Nursing Home Function Sunbridge Nursing Home Function Sunbridge Nursing Home Function Sunbridge Nursing Home Function Sunbridge Nursing Home Sunbridge Nursing Home Function Sunbridge Nursing Home Sunbridg | | • | | ELNORA ALBERTA BROWN | | | |
| Sunbridge Nursing Home Size Sundispenses Size Sundispenses Sundispense | | | | 4a Fecility Neme (If not institution, give street end number) | 4b. City, Town, o | r Location of Deeth 4c. C | |
| Direction The part | -57 | 0 | | Sunbridge Nursing Home | Elkton | C | ecil |
| Physician The Color of State The Color of Sta | | Funeral | | | | s. 8. Date of Birth | Birthplace (State or Foreign Country) |
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| The Monther's Names (First, Modes, Austices Survaine) The Monther | ğ | 2 hou | 8 | 15. Decedent's Education 16a. D | ecedent's Usuel Occupation | 16b. Kind | d of Business/Industry |
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| Physician Medical Examiner Physician Medical Examiner The property of the pr | ore | of He | | cemetery, | crematory or other place) | | |
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| Physician Medical Examiner Physician Medical Examiner The property of the pr | a E | amit. | | 21. Signature of Funaral Service Librasee | 22. Name and Address of Facility | Home of Ste | onhon I. Schaech |
| Physician (filedical Examiner) Part Continue Con | Ш | 205 2 2 | - 4 | M90510 | 118 West Cross | St. Galena, | MD. 21635 |
| Physician (filedical Examiner) Part Continue Con | | 1 60 | | 23a. Perti. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. | enter the mode of dying, such as cardi | ac or respiratory arrest, | Interval Between |
| Due to (or as a consequence of): Due to (or as a consequence of): | | Physician | | | | | Onset and Death |
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| Do Company of the control of the con | _ | end el-trar | xan | Sequentially list conditions, if any, leading to immediate | isequence of). | | 1 |
| Do Company of the control of the con | 9 | be e sician burie | ie | cause. Enter Underlying Cause (Disease or injury that initiated events | 1/1 | | |
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| 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Yeer) 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Sheelmohan S. Sachdev, M.D. 118 North St. Elkton, MD. 21921 31. Date filled (Month, Dey, Yeer) 32 Registrar's Signature | | a Physer this | ü | 27. Menner of Deeth 28e. Date of Injury 28b. Tin | ne of 28c. Injury at Work? | 28d. Describe how injury | occurred |
| 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Yeer) 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Sheelmohan S. Sachdev, M.D. 118 North St. Elkton, MD. 21921 31. Date filled (Month, Dey, Yeer) 32 Registrar's Signature | <u>ō</u> | ath. r: Aft | atio | 2 Accident investigation | | | |
| Doo23322 2/14/08 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Sheelmohan S. Sachdev, M.D. 118 North St. Elkton, MD. 21921 State 31. Date filed (Month, Dey, Yeer) 34. Registrar's Signature | <u>Vis</u> | er de recto by th | t t | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm building, etc. (Specify) | , street, factory, office | | Number or Rurel Route Number, |
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| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Sheelmohan S. Sachdev, M.D. 118 North St. Elkton, MD. 21921 State 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature | | 0 4 ¥ 5 0 | - | 1 | | | |
| Sheelmohan S. Sachdev, M.D. 118 North St. Elkton, MD. 21921 State 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature | | | | 20 Name and address of a second line 2001. | | 2/1 | 4/08 |
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| Registrar FFB 2 5 2008 Figure 15 April 19 19 19 19 19 19 19 19 19 19 19 19 19 | 150 | G CH | te | 31. Date filed (Month, Dey, Yeer) 3. Registrar's Signature | TIO NOTUL SE. | EIKTON, MD | . 41941 |
| | 1 | | | FEB 2 5 2008 See 15 19 | 00468 | | |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Month 8:05 P M Leo G. Crismer Jr. February 8 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death Gilchrist Hospice Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 8/21/1922 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) Days Hours 1 XM 2 □ F 215-16-2866 85 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits 1 TYes 2000 Md. Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4054 High Point Rd. 21042 USA 12. Was Decedent Ever in U.S. Armed Forces? 10/13- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 No. 1943 − If Yes, Give Year or Dates: 1945 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🔀 No Specify Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12vrs Plasterer Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leo G. Crismer Sr. Minnie L. Evans 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen A. Brehm/daughter 1314 W.40th Street Baltimore, Md. 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Ardent Crematory 2/11/2008 4 □ Donation 5 □ Other (Specify) Hanover, Md. 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Service Lice MOO845 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 Yes 2 DNo 9 Unknown Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ※ No 24a Was an 2 No 1□ Yes

Physician /Medical Examiner Examiner

permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once,

Physician

/Medical

Director

Funeral

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Completed

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Examiner

Funeral

Director

or? items 23a o

Pages 1 and 2 should be filed within 72 hours after death anent of Health and Mental Hygiene.
The marked other than "natural", or items 23, ant: If item 27 is marked other than "natural", or items 23, any or other traumatic event, the Medical Examiner must, ny or other traumatic event, the Medical Examiner must.

Baltimore, Maryland 21215-0036

with the Maryland r 28a-f show notified at

physician and s the burial-trans attending p for use as i

The law requires that the death certificate be executed

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Division or Vital Records, P.O. Box 68760,

Physician/Medical þ Be Certification: To

Q az

State Registrar

Medical

Completed 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPUE 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

29b. Signature and title of certifier

29c. License number 064395 29d. Date signed (Month, Day, Year)

30. Name and ad its s of person who completed cause of death (Item 23a) (Type, Print)

NOHARLESST, SUITE 209 BALTIMORE. MD 21204 6565 DANIEUS DOBERMAN. MD

31. Date filed (Month, Day, Year) FEB 11 2008

